VA MEDICAL CONSTRUCTION PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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VA MEDICAL CONSTRUCTION PROGRAM

WEDNESDAY, MARCH 16, 1983

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to call, at 9 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Mica, Dowdy, Evans, Harrison, Mollohan, Penny, Staggers, Rowland, Slattery, Richardson, Daschle, Hammerschmidt, Hillis, McEwen, and Johnson.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order. I would like to make an explanation before I have an opportunity to read my opening statement. A number of the Members on the Republican side will be a little bit late in getting here this morning because there is a Republican conference with the Secretary of State. Yesterday we had a very important Democratic Caucus and the chairman asked us to put off yesterday's hearing until today. I apologize to the witnesses and am pleased that they could reschedule themselves.

I would also like to mention to the Members that before you are two documents which I hope you will take some time to review. First is volume 4 of the VA budget submission for fiscal 1984, medical construction and leasing authorizations. The second is a 5-year medical facilities construction plan, 1983-87. These documents will be available for your use in questioning, particularly the VA witnesses this morning.

The Subcommittee on Hospitals and Health Care this morning will hear testimony on the VA's medical facilities construction program and the major construction projects for fiscal year 1984. Today's testimony, together with the VA's construction and leasing program budget submission, will assist the subcommittee and the full committee on Veterans' Affairs in the development of its construction and leasing resolution required by section 5004(A) of title 38, United States Code.

This provision requires the committee to adopt a resolution authorizing major construction projects for each fiscal year prior to the appropriation of funds for these projects. Major construction is defined as "any project costing $2 million or more." We are also required to approve any lease which would cost $500,000 or more per year.

The fiscal year 1983 construction program caused considerable concern due to the former Administrator's reevaluation of a reported $5 billion of medical facilities construction. Hopefully, we now have reevaluation behind us and we can avoid this kind of delay and added costs to future major construction projects.

The economic situation faced by this Nation and its concomitant high unemployment throughout the country makes the fiscal 1984 budget request for major medical construction a very high priority. The VA's 5-year medical construction plan submitted to us in June of 1982 and its medical construction and leasing authorization for fiscal year 1984 raises many questions.

This is highlighted by the fact that several Members of Congress have asked to appear before the subcommittee this morning in order to express their concern about specific projects that have not been included in the President's fiscal year 1984 major medical construction program.

For example, the clinical addition to the VA's Medical Center scheduled in the 5-year medical facilities construction plan for an estimated $44 million has not been included in the fiscal year 1984 budget request. Further, the VA Medical Center in Baltimore has again been placed as tenth in the priority listing for replacement hospitals. This project was previously authorized, but the appropriation of funds for its construction were rescinded in fiscal year 1981 at the request of the administration. It is my understanding the architect engineer's drawings are completed and it could be underway without any delay if funds were available for its construction.

Another project in question is the clinical addition to the VA's Medical Center in Clarksburg, W. Va. This projected $15 million addition was in the 5-year plan submitted in 1982, but no funds have been requested in the fiscal 1984 budget. I am sure that Mr. Mollohan will have some questions regarding this project.

Still another project is the VA Outpatient Clinic in Los Angeles, Calif. The Committee on Public Works discussed this matter and the Appropriations Committee appropriated $3 million for planning a VA replacement clinic on GSA property in downtown Los Angeles. On March 7, 1983, the committee received a prospectus on the construction of this independent outpatient clinic. The letter of transmittal refers to it as "an interim project prospectus." I am not sure what this means, but we intend to learn more about it in this morning's hearing.

The staff of the committee, as well as the General Accounting Office, has been exploring the cost of VA construction versus construction of comparable facilities in the State veterans home program. We hope to learn why there is such a marked difference in the cost of such construction projects.

We also hope to learn more regarding the three VA nursing home care units at Tampa, Ann Arbor, and Fresno in which the local hospital director has been made project manager versus those projects in which the management is maintained by the Office of Construction in the Central Office.

Before we call our first witnesses this morning, I would like to recognize the ranking minority member, the Honorable John Paul Hammerschmidt, for his opening remarks.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

The VA construction program has had the close attention of this subcommittee for a considerable period of time. We have seen it increase in size to the point where it is now approaching the $1 billion a year mark and the 1984 budget of more than $868 million is the highest in VA's history.

Mr. Chairman, we are witnessing a "catch-up" situation. The record is clear that for many years for whatever the reason, VA did not request and the Congress did not appropriate sufficient funds for the agency to update and modernize its tremendous nationwide hospital system.

Even with a construction budget the size of the one before us, it will still be years before VA has finished its task.

Mr. Chairman, the job has to be done and I hope that this year's budget is a forerunner of the future that realistically attacks the problem. Although we have a serious economic problem in the Nation, in my view making VA hospitals be up to the state-of-the-art in the delivery of medical care for veterans is a matter of high priority.

Mr. Chairman, you have referred already to the revalidation program of last year. It is my understanding that some 35 projects were validated and are the subject of discussion in the budget submission. It is my further understanding that 21 projects did not make the budget for a variety of reasons.

I hope that our witness from the VA, Mr. Alvarez, will speak to this matter this morning.

Mr. Chairman, I look forward to hearing from each of our witnesses about the construction program, how it is working and how it can be improved. We all want to perfect the planning process and we all want to avoid costly mistakes such as unnecessary changes in scope.

But Mr. Chairman, it has been my pleasure to see firsthand a number of VA construction projects such as the one in Little Rock. I think they are monuments to good medicine and on the whole, I think we can all be pleased with the many accomplishments that have occurred.

Later this morning, for instance, a new, beautiful $115 million hospital is being dedicated in Bay Pines, Fla. It replaces a hospital that is 50-years-old this very day. Our colleague, Mr. Bilirakis, is attending that dedication because many veterans from his district will be using the Bay Pines facilities and that is why Mr. Bilirakis is not with us for this hearing.

As you said, nearly all my colleagues on this side of the aisle are over with Secretary Schultz right now at a very important conference. I regret that they are not here for the opening of this hearing but we just have too many conflicts.

I, myself, have a serious conflict in about 30 minutes on the subcommittee on which you serve, Mr. Chairman, the Aviation Subcommittee and Public Works, so if I leave it is not because of lack of interest in this subject matter, I just have another firm commitment.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you. Are there any other opening statements that anyone would like to make?

[No response.]

Mr. EDGAR. I would like to ask unanimous consent that Members who have statements for the record be permitted to insert them at this time. Congressman Tom Downey has sent a statement [1] and there are a number of other members who may have statements to submit for the record and we would like to add that at this moment.

Mr. EDGAR. Our first witness will be the Honorable Marjorie Holt. We appreciate her presence here this morning and Marjorie, we invite you to the witness table.

We have your full statement and it will be made a part of the record. We invite you to proceed as you see fit.

Mrs. HOLT. Thank you, Mr. Chairman. I would like to submit a statement for the record and summarize my remarks.

STATEMENT OF HON. MARJORIE HOLT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mrs. HOLT. You certainly expressed very well the concern that we all have. I know that this subcommittee is deeply concerned about the health care needs of America's veterans, and I appreciate very much the opportunity to appear here to address this little jobs bill that I am proposing.

We have an opportunity in Baltimore, and I know that you are aware of it, keenly aware of it, to provide acute care and outpatient services for veterans in partnership with a great medical center that we have there, the University of Maryland. The project is planned, designed and ready to go. I am advised that construction could begin tomorrow if funding were available. Bids on the first phase of construction had already been received in 1981 when Congress rescinded the appropriation for this hospital.

Baltimore is an old, depressed city and this would be an opportunity to quickly put some of our money to work to solve the unemployment problems. The cost estimate in 1981 was $96 million. I have spoken with Dr. John M. Dennis, the vice chancellor for health affairs at the University of Maryland, and he and the architect believe that we could count on that price remaining stable because of conditions in the construction industry.

The university has invested more than $3 million to accommodate the facility. They have donated a site of land. It is ready to go. They have made every preparation for it. We need it desperately. I know that every member of this committee is aware of the problems that we are facing today as our veterans age. We are short in bed care. We are short in long-term care.

We have the Loch Raven Hospital in Baltimore which is 6 miles away. Our veterans have to go out from the city to Loch Raven when they need hospitalization, and then return to the outpatient facilities downtown for followup care. It's a very, very unsatisfactory arrangement. So this would give us the opportunity to consoli-

[1] Statement of Hon. Thomas J. Downey appears on p. 47.

date the acute and out-patient care in one facility and return the Loch Raven Hospital to long-term care.

So I hope that you will seriously consider this for inclusion in your authorization bill at this time. Thank you very much.[1]

Mr. EDGAR. Thank you very much for your testimony. Can you give any reason as to why the Baltimore VA Hospital project has been bounced around as much as it has within the system?

Mrs. HOLT. Well, I think it was a matter of fiscal constraint, trying to find places that we could stop spending money. I think that everybody that I have talked to in OMB and in the administration recognizes the need for it, recognizes the merit in it. I haven't had anybody question that at all. It's simply trying to stretch dollars as far as we can.

I think now that everybody is recognizing that we do have to spend some money to create some jobs, and this is one that is ready to go, so I think that it is right now to consider construction of this hospital facility.

Mr. EDGAR. Do you know what the unemployment rate is in the area of this particular facility?

Mrs. HOLT. It's about the national average in that vicinity. In Baltimore it is much higher in the black communities, but it's about the national average there. In Baltimore—it's lower in Maryland totally, but in the city it's about 10.2 percent.

Mr. EDGAR. Thank you.

I yield to my colleague, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Marjorie, very much for your testimony. It is my recollection and understanding that Baltimore was about ready to go but negotiations of a 8(a) small business set-aside got bogged down and were the cause of this project not being started. I think if we could overcome that hurdle, we could create some jobs right away.

Mrs. HOLT. I think that that has been reconciled. That was one of the problems, but I believe—that's why I feel so strongly that the time is right. Now, you see, labor is willing to make concessions. Everybody is willing to make concessions because they realize that this kind of debate can really stop progress and this is something that we need to go forward with.

Mr. HAMMERSCHMIDT. Thank you very much, Marjorie.

Mrs. HOLT. Thank you.

Mr. EDGAR. Any further questions?

Thank you very much for your testimony.

Mrs. HOLT. Thank you.

Mr. EDGAR. We really appreciate your coming.

The Honorable Jack Hightower has joined us and we will ask him to take the witness stand.

We are pleased to have you here this morning. Your full text of your statement will be made a part of the record and we ask you to proceed as you see fit.

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[1]Statement of Hon. Marjorie Holt appears on p. 47.

STATEMENT OF HON. JACK HIGHTOWER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. HIGHTOWER. Thank you, Mr. Chairman. I understand that you have already made some reference to the Amarillo Veterans Hospital facility and we appreciate very much the interest of the subcommittee and of the committee in the hospital service to the veterans of that very large area.

I am concerned about the planned deferral of funding for the next fiscal year and possibly even longer, and it's that longer deferral that gives me great concern. I maintain that a longer deferral is unjustifiable and if it is allowed to continue it will work an undue hardship on a facility that has already had to struggle for many years to adequately take care of its veteran patients.

There is no doubt about the need for the expansion of the facility in Amarillo. In hearings before this subcommittee last year, the project was scheduled for inclusion in the 1984 budget because of the urgent needs for the psychiatric services the completed project will provide.

In a report by a project review committee to the Veterans' Administration's facility planning and construction committee, the Amarillo VA Medical Center was said to need expansion because "services have been fragmented and existing spaces are too small to allow for efficient patient care."

In a 1981 report, the VA's own facility planning and construction committee recommended "that the need for a clinical project to correct functional, space and privacy deficiencies be considered a serious need at the VAMC Amarillo * * *. Major deficiencies exist even to meet existing workloads."

The Amarillo VA Medical Center was constructed in 1939, 44 years ago, and since that time no major renovation has taken place at the facility. Surely all of this leads to the inevitable conclusion that the Amarillo Medical center needs and deserves funding for its expansion.

The original plans, beginning in about 1975, were made with the concurrence and the guidance of the VA Central Office, and as of last year were proceeding to the final construction plan phase.

Because of a decision by the Veterans' Administration Central Office, all construction plans scheduled for funding in the 1984 budget were revalidated, as I am sure you know. When this revalidation was conducted at Amarillo that the preliminary design for the facility was faulty and needed some structural changes. Even though this was a disappointing setback, the Amarillo facility—already termed to be seriously deficient with its existing facilities to meet current patient needs—agreed to the changes made by the Central Office and accepted the new conceptual plans.

The agreement on the plans for the facility at this point really seems to end. The medical center itself, as well as some of the VA's Office of Construction staff, agree that the most cost-effective and efficient manner of proceeding is to use the architect who was responsible for the original plans. The VA General Counsel's Office, however, has not firmly endorsed the use of the same architect for the newly conceived plans, instead now maintaining that proceeding with the original architect can only be supported if the record

would show that the VA would achieve a significant cost savings by doing so.

I believe that this misplaces the burden of proof; the Amarillo VA facility should continue with the same architect unless some good reason not to do so is demonstrated.

If the VA at this late date chooses to begin again and to search for a new architect, the planned construction at Amarillo would be delayed indefinitely and the costs escalated unnecessarily. Use of the same architect for the new expansion has several advantages, both for the veterans of the western region and for the U.S. Treasury.

First, there would be no leadtime on the project. The current architect already knows the plans for the facility and has invested a considerable amount of time and taxpayer money in working with those plans and with the people trying to implement them.

Second, the design changes put forward by the VA are minimal enough that they can easily be incorporated into the current design plans. Most of the current architect's plans would be kept in the new designs.

Finally, it is surely more cost effective to continue with a plan that is already underway, rather than interrupt an entire process that is nearly complete only to begin again at square 1.

Mr. Chairman, the VA Medical Center at Amarillo began its plans for expansion in 1975. For over 8 years now they have waited to expand this facility and we hope that the plans will move along expeditiously. It is always disturbing, I know, to you, to members of the committee and to Members of Congress to see unnecessary delays, expecially when those delays prove to be costly. It's more and more apparent to us that we have got to find efficient ways to use every taxpayer dollar, and of course, there is no more efficient way than in providing for necessary medical care for veterans. But even in doing so, we want to do the very best job we can. I know you do and I appreciate very much the cooperation of the subcommittee.[1]

Mr. EDGAR. We thank you for your statement, which is very thorough and very helpful. At this point, the confusion over the selection of architects I know, is disturbing to you.

I would remind you that there are a couple of hospitals that have been built recently, one in the Bronx that had very fine designers that have not turned out so well. Operating rooms were placed over loading docks, the building does not have proper water pressure or proper fire and safety specifications.

So whoever does it, I would hope that you and your office might take a look over their shoulder just to ask some of the commonsense questions that need to be asked in putting a hospital together in terms of its basic construction. Your statement is clear and I really appreciate it this morning.

Mr. HIGHTOWER. Well, thank you, Mr. Chairman. I am very conscious of what you say and certainly support redoing it completely if that was necessary. We have been following it closely. I have had several visits with the architectural team. I have looked at preliminary drawings. I have walked the building. We have stayed very

[1]Statement of Hon. Jack Hightower appears on p. 48.

close to it because it is of very special interest to me, a very fine hospital in an area that—the area where the hospital is located has been built up now as a medical center. Texas Tech Medical School has a building there. There are three new major hospital facilities built in that complex. It is a potentially very fine operation and we want it to be the very best, and for that reason, have been looking over their shoulder already.

I am thoroughly convinced, not just on someone else's say-so, but from my own investigation, that the plans are basicaliy sound and the changes proposed are minimal.

Thank you very much.

Mr. EDGAR. One moment. I yield to my colleague.

Mr. HIGHTOWER. Certainly.

Mr. HAMMERSCHMIDT. I was going to thank you for your fine testimony and appreciate your personal interest in that hospital, of course, in your district.

We were disappointed, too. I know that was in the tentative budget for about $40 million, if I remember right, and it is too bad that you got into this architectural problem. It may be, and we will inquire of Mr. Alvarez when he comes before us, it may be that the VA has their hands tied a little bit by the Brooks bill in the selection of architects. I am not quite sure how that falls out in this particular case.

But we are disappointed along with you because there is a requirement on advertising and so on, as mandated in another committee. But I want to assure you that it has our full attention and we very much appreciate you being here this morning.

Mr. HIGHTOWER. Well, thank you, Mr. Hammerschmidt. I have not checked the point on the Brooks bill, but I appreciate you calling that to my attention.

Thank you very much.

Mr. EDGAR. Are there any other questions?

[No response.]

Mr. EDGAR. Thank you very much, Jack, for your comments.

We will now hear from the Veterans' Administration, Everett Alvarez, Jr., Deputy Administrator of the Veterans' Affairs, and I am sure you have some colleagues that will be joining you at the table.

Mr. Alvarez, we are pleased that you are here this morning. We have a large number of members who are here who have questions and concerns that they would like to put to you.

Your full opening statement will be made a part of the record at this point, without objection. We ask that you proceed as you see fit. It would be helpful, if, before you begin reading your statement or giving your opening testimony, you would introduce those who are with you at the table.

STATEMENT OF EVERETT ALVAREZ, JR., DEPUTY ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION; DR. WILLIAM JACOBY, DEPUTY CHIEF MEDICAL DIRECTOR; MR. WILLIAM SULLIVAN, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS; MR. WILLIAM SALMOND, ASSISTANT DEPUTY ADMINISTRATOR FOR CONSTRUCTION; JOHN MURPHY, GENERAL COUNSEL; AND ROY McCRACKEN, DIRECTOR OF THE FACILITY ENGINEERING, PLANNING, CONSTRUCTION OFFICE OF THE DEPARTMENT OF MEDICINE AND SURGERY

Mr. ALVAREZ. Thank you, Mr. Chairman, and members of the subcommittee. I am pleased to be here today to discuss the VA's medical facility construction program, our request for authorization for those construction projects by the Committee on Veterans' Affairs, and our 5-year construction plan for fiscal year's 1983–87.

I would like to introduce on my far left, Dr. William Jacoby, who is our Deputy Chief Medical Director. On my immediate left is Mr. William Sullivan, our Associate Deputy Administrator for Logistics. Next to me, on my right, is Mr. William Salmond, our Assistant Deputy Administrator for Construction. On my far right is Mr. John Murphy, our General Counsel.

Mr. Chairman, the Veterans' Administration hospital system includes 172 medical centers located throughout the United States, which provide a comprehensive range of health services to our Nation's veterans.

Our system operates in over 5,000 separate buildings with over 100 million square feet of space. Like the veteran population that we serve, this VA physical plant is aging. As you have heard from the previous witnesses who have aging facilities in their districts. I would like to point out that 53 percent of the VA hospital beds that we have are housed in buildings which are over 30 years of age.

The majority of the VA medical centers were constructed without significant outpatient capability, and while many improvements to our medical facilities have been accomplished, a great deal remains to be done.

The delivery of quality medical care demands a commitment to a capital investment program which preserves and protects facilities and provides improvements to keep pace with state-of-the-art, modern medical care. Program enhancements, rapidly advancing technology, the demands of modern health care, code changes, standards of the Joint Commission on the Accreditation of Hospitals, and the need to eliminate architectural barriers all contribute to the need to make improvements.

As you know, our proposed fiscal year 1984 construction budget now before the Congress is the largest construction budget ever proposed by the Veterans' Administration. This proposal reflects a continued strong commitment to meeting the facility needs of a modern, comprehensive, health care delivery system for our Nation's veterans.

Our major program level request of $753 million includes funding for 35 projects, including the replacement hospital in Minneapolis, Minn., 7 nursing home care units which will provide 840 new nursing home care beds, and other improvements in medical center support areas.

We are requesting the authorization of major construction projects as detailed in volume VI of our budget submission. Of the 35 projects for which funding is requested in fiscal year 1984, 29, at an estimated cost of $299.1 million, require the authorization of this committee. The remaining projects have been previously authorized by your committee.

We are also requesting your authorization to proceed with working drawings in fiscal year 1984 using VA staff for five major construction projects planned for fiscal year 1985, and we further request lease authorization for the relocation and expansion of the VA outpatient clinic in Portland, Oreg.

Our 5-year plan for fiscal year 1983–87 identifies projects having a current estimated cost approaching $5.5 billion. These projects will provide needed improvements at VA medical centers allowing us to keep pace with the many changes in technology, levels and types of service, and health care delivery methods.

Our Department of Medicine and Surgery's medical district initiated program planning process (MEDIPP), will strengthen facility plans by providing firm, programmatic plans for the delivery of service and thus, a stronger foundation upon which to undertake specific facility planning.

These individual facility plans are the basis on which our 5-year plan is built. Mr. Chairman, and members of the committee, we believe that our 5-year plan offers a responsible approach for meeting the facility needs of the VA health care system.

It represents what we believe to be required to keep the VA medical facilities in an acceptable condition. We recognize, however, that available resource levels may necessitate changes in this plan as we move toward its implementation.

Mr. Chairman, this completes my presentation. I shall be pleased to respond to any questions you or the members of this subcommittee may have.[1]

Mr. EDGAR. Thank you very much. Before we move to questions, and I will save my questions until the end, I wonder if you might take this volume VI, 1984 document, if you have one available to you there, and just for the basis of our members, you mention in your statement some 35 projects. We know that there is a 5-year construction plan. Can you just walk through it and teach us a little bit about how to use this document so that we are clear with you as to what your priorities are?

Mr. ALVAREZ. I understand your question.

Mr. EDGAR. What are your priorities?

Mr. ALVAREZ. I am just trying to determine which of my colleagues here would be able to give you a better presentation of that than I would.

Mr. Chairman, I would like to ask Mr. Roy McCracken who is with us today to respond because he is an individual who can better handle your question than I.

Mr. EDGAR. I didn't mean to traumatize everybody with the question. The question is, we are here reviewing lots of paper on a day-to-day basis, and I just want to make sure that we are clear in our

[1]Statement of Hon. Everett Alvarez, Jr., appears on p. 50.

ability to read what the priorities of the VA are for 1984 funding, what your 5-year priorities are.

Mr. ALVAREZ. Mr. Roy McCracken from our Department of Medicine and Surgery will outline it for you.

Mr. MCCRACKEN. The authorization request document is a detailed listing of projects for which the agency is requesting authorization by the committee for fiscal year 1984. It includes a project description, estimated cost, and other information. The volume also reports the status of projects which the committee has previously authorized.

In regard to the issue of priorities, we have given first priority to previously funded projects, such as when you request a design in one year anticipating construction the next. We have placed these at the top of the priorities in order to continue the commitment to the Congress implicit to prior funding request.

The next priority would be the extended care, the nursing home issue, realizing again we are looking to 1987 and a 13,100-bed commitment. The third priority would be in relationship to fire safety, patient privacy issues. And then beyond that point we would be looking at a balanced program which would include clinical additions, outpatient additions, warehouses, laundries, to make sure that we maintain a balance.

I hope that answers your question. If not, I will be glad to be more specific.

Mr. EDGAR. Yes, it does. I have other questions that I want to ask relating to that, but I wanted members to understand how they could read those documents to find out what your 1984 fiscal year priorities are. I have further questions dealing with how you come about selecting certain projects.

Mr. Alvarez, you talked about the age of the system. Is age a factor in determining priority of replacement of facilities? How much does that push a project up? How projects involving hospitals that are 20 years old and are replaced somehow sneak up ahead of others that might be older. But let me hold off on those questions and yield to my colleague.

Mr. Hillis.

Mr. HILLIS. Thank you, Mr. Chairman.

Let me ask just a couple of questions for the record. One, could you clarify the number of beds that have been closed in the past few years due to construction-related, things such as fire prevention, safety, or privacy? Could you identify for the record where the hospitals are where the reductions have taken place?

Mr. ALVAREZ. Sir, let me defer that question to our Department of Medicine and Surgery

Dr. JACOBY. I have to say that there are two types of knowledge. I guess one is having it first-hand and the other is knowing where to find it. If I can beg your indulgences at times, I will thumb through my book so that I can get some of this information.

The entire DM&S system was carefully evaluated in 1978, at which time it was determined that approximately 12,900 beds would be required to be closed in order to meet fire safety and privacy considerations.

Up to this period of time, there have been 4,400 beds that have been closed in reference to these various categories and we have

recently reevaluated the system and would anticipate that we have approximately 5,400 beds that will be closed as we make patient privacy and fire safety improvements. Although our original estimate was a 12,900-bed loss, our current estimate for that total loss is about 9,800 beds.

I would have to provide detailed information for the record. That is an extensive listing.

Mr. HILLIS. That would be fine.

[The information appears on p. 118.]

Mr. HILLIS. That leaves this question. It has been suggested by some that a number of these beds that have been closed could have been converted to nursing care beds. It has also been stated that you could still convert some that you have to do modernization. On the other hand, the VA has testified that those beds were closed due to construction related to fire prevention, safety and privacy.

If that is in fact the case, how could you convert some of them to nursing home care beds? Would you comment on this area generally?

Dr. JACOBY. Mr. Hillis, the original establishment of nursing home care beds within the VA was done with that principle in mind. The original VA nursing home care beds were a conversion of existing hospital beds.

Now one of the factors that has played a significant part in our planning has been our MEDIPP process and I hope, as the chairman indicated, we can come back and talk about prioritization because I think this plays a factor. But under the medical district initiated planning program, we did provide direction to each of the districts that, in considering their planning for nursing home care beds, they would look at their requirements. Is it possible to accomplish those requirements within the existing beds or is new construction required? At the same time, they should also look at the requirement in relationship to State facilities that were available and also the private sector.

But in many of our areas in the MEDIPP planning we are looking at the possibility of conversion of existing hospital beds to nursing home care beds.

Mr. HILLIS. One final question. In keeping with the changes in medicine today and the way treatments are administered and the aging of the veterans population—the average World War II veteran now is approaching 60—do you see a greater or lesser need for outpatient facilities and outpatient care for the veterans population?

Dr. JACOBY. I believe that the system, as tested over the past 10 years, has demonstrated the need for outpatient care. This is a significant factor in why beds were reduced. Beds were reduced not only to address fire safety and privacy considerations, but as a result of increasing productivity. If you consider the turnover rates which have occurred in VA hospitals, I think it is absolutely superb to see what has been done in reducing the length of stay and increasing productivity, thereby utilizing fewer beds to accomplish our mission. But also a significant factor was the fact that the Congress did authorize the utilization of outpatient care. What we tried to do is get a balance between inpatient and outpatient care,

and although the patients are aging, we think that we will continue in the years ahead to use a high degree of outpatient care.

Mr. HILLIS. Thank you.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you very much. We are going to operate under the 5-minute rule so that everyone can get at least a first round of questions in with the VA and we will do that with a leeway in case there is a particularly important question that gets considered and we will come around for second turns for those who have additional questions.

Mr. Staggers.

Mr. STAGGERS. Mr. Chairman, I have no questions at this time.

Mr. EDGAR. If someone has to leave really urgently, speak up and we will allow you to go out of turn.

Mr. Mica.

Mr. MICA. Thank you. I will just make it brief, 30 seconds or so.

First, the testimony of the national commander of the Jewish War Veterans says, and I quote, "I feel this plan is not adequately addressing the present and future medical needs of veterans in the State of Florida." I am particularly pleased to see them mention this from a national standpoint, because more and more national organizations are recognizing the critical nature of our problems down there.

Are you all aware, is every one at the table aware of something called "The Thirty-Year Study for Florida"?

Is anybody not aware of it?

Mr. ALVAREZ. No.

Mr. MICA. What actions are being taken right now in concert with this budget, and I don't see anything in this, to start to implement that?

Mr. ALVAREZ. Mr. Mica, I missed the last part of your question.

Mr. MICA. What actions are being taken to implement that? Do you have a team down there to assess when you are going to start building?

Mr. ALVAREZ. The 30-year study that you refer to reiterated the needs in the State of Florida. We recognize the needs throughout the State of Florida. What we have done, Dr. Jacoby can amplify on. But the needs of Florida are being considered very seriously along with the needs of all the other States and territories, Puerto Rico, et cetera, in our overall MEDIPP planning process which takes these needs, weights them and balances all of the needs, one against the other, in developing this program that we have. It is all part of the planning process. We are actively working on this planning process, and I can assure you that the needs that you mentioned in Florida are being considered seriously, along with the rest of the Nation's needs.

Dr. Jacoby, can you amplify on that?

Dr. JACOBY. The 30-year plan is obviously very well-known to every one in the Department of Medicine and Surgery. I think as one looks at the State of Florida there are probably three categories of facilities and prioritizations, if you will, that are occurring. First of all, there are projects which are already underway. The chairman mentioned that the new hospital at Bay Pines is being dedicated today, so that is a big addition to the State of Florida.

There is a 120-bed nursing home which will be at Miami, and 120-bed nursing home at Lake City.

Now these are all currently underway. In the second category are those projects which are proposed and which are already in the 1983-1987 plan, affectionately know as the "Green Book" We are talking about a major addition and a very significant one of 290 beds at Gainesville for acute psychiatry and I think this is an important need which has got top priority from DM&S's standpoint.

We also have an outpatient and clinical addition planned for Lake City and a clinical addition is planned at Tampa.

The third category would involve again new construction, the establishment of new programs, and I think that this is where the MEDIPP process comes into play because obviously what we have done is looked at the 1980 census which is so important to the State of Florida and then based on what we see the demands and requirements in Florida, to try and outline a program.

The recommendations of the 30-year plan would require $695 million, and that is a large amount of money and project development works which obviously could not be accomplished in one budget year. So we will very strongly consider what our MEDIPP recommendations are and balance that against our requirements within the rest of the country in order to determine what our future plans will be in that third category.

Mr. MICA. I think that is an excellent point. It needs to be balanced against the rest of the country and everybody on this committee is interested in that one portion. Before I ask you about it, let me just remind you, everything you have mentioned, every single project you have mentioned, has been in or on this budget in the 1970's before I was ever here from the 1970 census, based on critical needs long before the 30-year study was done. So I think the entire committee, if I may ask them not to talk about Florida, would be interested in the results of the MEDIPP plan. We have been hearing about it for 2 years, which ones are going to close. Do you have some information for us?

Dr. JACOBY. Mr. Mica, I could only tell you that the 290 beds, for instance, acute psychiatry beds, although the need was there, that is a program which came up within the last several years and was actually placed on the list of 10 because we recognized that need in Florida.

Mr. MICA. Are you going to give all of us a rundown for each of the regions in the country as to what the results of this plan is that we have heard about for all of these years about openings, closings, expansions, and so on.

Dr. JACOBY. What will happen in the MEDIPP plan is, and I would not want to overemphasize the MEDIPP plan, this is an embryo effort, if you will. It was born in November and it really has been a very excellent exercise. We are really pleased with it for a first effort. We are presenting that to the CMD, and before the end of the month, it will presented to the Administrator.

Mr. EDGAR. Would you mention what "CMD" is?

Dr. JACOBY. Oh, Chief Medical Director, Don Custis.

Mr. EDGAR. Thank you.

Dr. JACOBY. And as soon as Dr. Custis and Mr. Walters have signed off on this year's plan, it will be available.

Mr. EDGAR. Mr. Dowdy.

Mr. DOWDY. I have but one question. I was contacted by some concerned people within the last several days and I noticed that their concern apparently will be reinforced by testimony to come later from the representative of the Disabled American Veterans. That has to do with the testimony about the change in the number of acute-care beds to be made available within the VA health care program. I will read this, and then I will ask you to respond to it. "In our view, the continual shutdown of acute-care beds will relegate the medical care program to a caretaker system for elderly veterans." The concern, which I understand will be expressed later and the concern which has been expressed to me, is that with the decrease in the number of acute care beds of elderly veterans, and then the statement goes on, "But what of the similar needs of the more than 8 million Vietnam-era veterans whose average age by the year 2,000 will be 53 years."

Are these concerns well founded in your opinion?

Mr. ALVAREZ. Mr. Dowdy, I feel Dr. Jacoby could best answer that question.

Dr. JACOBY. If we look at a balanced health care system, which is what we are trying to achieve, the reduction in acute-care beds will be balanced by changes which would occur in extended care facilities, and principally in our nursing home care program.

At no time has DM&S lost sight of the fact that medicine is dynamic. A patient can be in one category of bed regardless of age, because nursing homes do have patients that are in the 35- to 40-year group as well, depending upon their condition. Patients does move back and forth, and the question is, how many acute-care beds do we really need in order to take care of eligible veterans; and we are trying to do that by looking at our demographics, and through our MEDIPP planning process. I could only submit at this time that we will not reduce out acute-care beds at the expense of a long-term care system. It would not be wise, not only for the veterans who require the care, but an unbalanced system is a very difficult system to maintain.

We would be unable to attract the type of physicians, nurses, and other medical professions who make up a good health care system, if you have nothing but chronic care. So Dr. Custis in his directions, is trying to get that balanced system and there is never any intent to change the system to a chronic care system.

Mr. DOWDY. Thank you. That's all I have, Mr. Chairman. Thank you.

Mr. EDGAR. Thank you very much. Before moving to Mr. Harrison, let me just mention to everyone that on March 24, the subcommittee will conduct hearings on the readjustment counseling program for Vietnam-era veterans I just want to bring that hearing to your attention. We will look at legislation, H.R. 1443, which would extend the counseling services for an additional year. I hope many of the members can participate.

Mr. Harrison.

Mr. HARRISON. Thank you, Mr. Chairman. Mr. Administrator, I just want to follow up a little bit on what Mr. Dowdy started to talk to you about because it seems to me that the medical needs of our Vietnam-era veterans are really not fully known, that this is

an ongoing misfortune that we keep finding out how bad things are. And I think that we also know that the plans for construction of new facilities or for upgrading old facilities is sometimes put off from year to year because of financial reasons.

So I guess my question is this: Is there within the VA an ongoing study of what are perceived to be the medical facility needs of Vietnam-era veterans in the years to come? Do we have a handle on what their problems are likely to be and what we should be planning now so that maybe when this Green Book gives way to another Green Book, why, we will see the facilities actually underway?

Mr. ALVAREZ. Mr. Harrison, before I ask Bill Jacoby to comment on facility needs for the Vietnam-era veteran, I would just like to point out that the VA for the past several years has had considerable interest and a lot of resources allocated to addressing the needs of the Vietnam veteran. For example, we have the Vietnam veteran readjustment counselling program where we have 136 counseling centers around the country, closely linked with VA medical centers and working extremely well. It is a very successful operation.

I think it is a very popular program. In the last 2½ years we have seen 125,000 Vietnam veterans use this program. We have a lot of ongoing work, which Bill can address, such as research in post-traumatic stress.

Yes, we are actively involved in addressing the needs of the Vietnam-era veteran. Along with that, we are addressing the future medical care facility needs of the Vietnam-era veterans.

Bill, at this point, I do not know if their facility needs are remarkably different from World War II veteran needs and Korean veteran needs. Can you follow up on that?

Dr. JACOBY. I would agree with Mr. Alvarez. Much of our current planning data is on the basis of 1990, however we are certainly looking at 1995 and out past the year 2,000. The MEDIPP grassroots planning process took that into consideration as well as the age and other health related characteristics.

We have a patient treatment file that contains disease specific information. By the way our data doesn't vary from the private sector. As the individuals get older, of course, they do get different types of illnesses and we do look at that in our planning cycle.

So in MEDIPP we look at demographics and then on the basis of those demographics we determine our needs, and then we convert that into what our construction requirements are.

Mr. HARRISON. Thank you. I am aware of the counseling program and I agree with you that it is doing great good. I am just asking this question, I guess, to get a general statement from you in response to what a lot of the Vietnam era vets in my district say to me, which is that the entire VA medical care system is geared to the needs of older veterans and that by doing that we are setting up some sort of a tension between those of Korea and World War II and the younger guys. They say, "We don't know how debilitating our diseases may be. We don't know what all the consequences may be. We don't know whether the system will be there 10 years from now if we need it for what may be unforeseen consequences of what has happened."

I am looking for some assurance that the VA is aware of this.

Dr. JACOBY. I believe that the VA is seeing to the needs of the Vietnam-era veteran and looking toward the future. I would also point out that the age of the Vietnam vet ranges from probably the early thirties to maybe sixties because there are Vietnam veterans who were in their forties serving over there. So in our planning we do look at that whole age group and can reassure them that we will do everything that we can to preserve that acute care system because it is the real heart of our entire health care delivery system.

Mr. HARRISON. Thank you very much. Thank you, Mr. Chairman.

Mr. EDGAR. Mr. Mollohan.

Mr. MOLLOHAN. Thank you, Mr. Chairman. I would like to thank you especially for your opening remarks during this hearing and in a previous hearing in which you made reference to the Veterans' Administration medical center in Clarksburg. Your expression of interest is certainly appreciated by me. I want to thank you for that.

I would like to follow up on that reference and explore that project with our witnesses here today.

Mr. Alvarez, there is a project within my district. It is a very significant medical VA facility the First Congressional District of West Virginia and it is one in which I have a real interest.

The project is obviously important to West Virginia as it serves our veterans who, I think you will agree, have made an inordinate contribution to this nation in terms of their service in the military.

West Virginia makes a disproportionate contribution, I think, to that effort in this country, and I know you recognize it. The project is important because it serves those veterans. Also, the project is important because my State has the unhappy distinction of presently experiencing 20.4 percent unemployment. It is also important that we can bring projects in on time in accordance with their original schedules—this project was projected in your 5-year plan which was published in June of 1982 or 1981. It's important to carry it through, to keep it on line and on time.

I would like to explore with you today that project and how we can do that. Do you understand that this facility is 35 years old and it is a major VA medical facility in our area?

Mr. ALVAREZ. Mr. Mollohan, yes, we are fully aware of the status and the age of the Clarksburg facility in your district, as well as others in the region. Perhaps, Bill Jacoby can respond in more detail.

Dr. JACOBY. I would, again, agree with you in your analysis of Clarksburg. It is a facility built in 1939. It is strongly affiliated with the University of West Virginia as a teaching facility, and is an important hospital within the VA system.

We had a little problem in that area and it centered around basicaliy trying to determine what our needs were. As you know, a good percentage of our planning was done on 1970 data, the census data. As we received the early returns on the 1980 data, it became obvious to us that some of the 1970 data had changed. So we did various types of analysis as early as we possibly could and we did show that in the Clarksburg area by 1990 we probably would have

a 12-percent decease in the number of eligible veterans within that district.

Based upon this and some changed requirements on the clinical side in regard to additional beds that we needed in, for instance, dialysis, we were trying to determine what our current bed needs were. The time frame needed to accomplish preliminary plans and to order to meet the 1984 budget, could not be met. At the present time I think we are on track with that project. It is still an important project to us also.

Mr. MOLLOHAN. There are a few problems here. No. 1, you said you couldn't incorporate it into your 1984 budget plan so therefore, by definition, you are not on track, because you should have been able to incorporate it into your 1984 plan.

Dr. JACOBY. We couldn't put it into the 1984 budget because first of all, the changes in demographics resulted in changes in bed requirements—one of the things we are very careful about at this time is to not only provide quality health care, but provide quality health care in a cost-effective way.

Mr. MOLLOHAN. Right.

Dr. JACOBY. So as a result we were trying to make sure that we sized that hospital appropriately, and when we did that we could not complete the preliminary plans in time.

Mr. MOLLOHAN. I would like to discuss this with you Doctor. You do agree that a renovation is essential in this 35-year-old hospital if it is going to maintain its usefulness?

Dr. JACOBY. I totally agree with you.

Mr. MOLLOHAN. You agree with that. And you do agree that it was in the 5-year plan submitted in June of 1982, do you not?

Dr. JACOBY. I agree.

Mr. MOLLOHAN. Now I understand that there have been some adjustments in the requirements, but we don't find any funds in the fiscal 1984 budget for the project. Do you agree with that also?

Dr. JACOBY. I agree.

Mr. MOLLOHAN. Let me go through the events with you a little bit Dr. Jacoby, then if you are going to carry this ball.

We went through the advanced planning process in October 1981, for this project, did we not?

Dr. JACOBY. I would think that would probably be the appropriate schedule, yes.

Mr. MOLLOHAN. Well, let me ask you, do you know the answer to that question?

Dr. JACOBY. Mr. Salmond can probably address that part better than I.

Mr. MOLLOHAN. In April 1982, Dr. Jacoby, if you are going to continue with this, we got approval from the VA Administrator to get a contract for the architect and engineering work. Isn't that correct?

Dr. JACOBY. Mr. Salmond indicates that is correct.

Mr. MOLLOHAN. Mr. Salmond, then if we are going to pass over to you, in May of 1982 these A&E people visited with the Clarksburg folks, did they not?

Mr. SALMOND. Yes.

Mr. MOLLOHAN. And I think at that time we added a radiology requirement to the specs?

Mr. SALMOND. Right.

Mr. MOLLOHAN. And then in July of that year the concept was adopted by the Department of Medicine and Surgery? Is that right?

Mr. SALMOHD. Yes, that's correct.

Mr. MOLLOHAN. And they were to go ahead with the proposed preliminary plan?

Mr. SALMOND. Yes.

Mr. MOLLOHAN. And we had the architect firms from Charleston and Washington do that, did we not?

Mr. SALMOND. Right.

Mr. MOLLOHAN. And then the project was submitted for approval in November 1982. Is that correct?

Mr. SALMOND. Yes.

Mr. MOLLOHAN. And we got approval by the VA Administrator, did we not, for the concept?

Mr. SALMOND. Yes.

Mr. MOLLOHAN. Now, what we are involved in here now at this time as I understand it, and please clarify any misunderstanding I might have, is putting together a final plan. That's a process that involves the architects, the engineers.

Mr. SALMOND. Yes.

Mr. MOLLOHAN. And you estimate that that plan will be brought in, and this is the only requirement that is necessary at this point prior to breaking ground. Is that correct?

Mr. SALMOND. No, we need to complete the preliminary plan.

Mr. MOLLOHAN. Well, that is what I said. You need to complete the preliminary plan and get it approved——

Mr. SALMOND. Yes, before we can request the money in a budget.

Mr. MOLLOHAN. You need to complete the preliminary plan before the architects draw up specific plans. Is that correct?

Mr. SALMOND. Yes, that is correct.

Mr. MOLLOHAN. I was a little bit ahead of myself. Now you expect to have that preliminary plan completed prior to the fall of this year; isn't that correct?

Mr. SALMOND. Yes.

Mr. MOLLOHAN. Now, in order to progress beyond that point in the fiscal year of 1984 you have to have money, don't you?

Mr. SALMOND. Yes, we have to have authorization and funding.

Mr. MOLLOHAN. The authorization comes from here, isn't that correct?

Mr. SALMOND. Yes.

Mr. MOLLOHAN. But for you to proceed you have to have money?

Mr. SALMOND. Yes.

Mr. MOLLOHAN. So it is conceivable and actually probable, based on events up to now and your projected little scenario there for this next 6 months or so, that you will have a preliminary plan waiting in August or September or October of this year, and find yourself with no money to proceed with this project for 1 whole fiscal year unless we get it approved this year. Isn't that correct?

Mr. SALMOND. Yes; that is correct.

Mr. MOLLOHAN. Well, all kinds of things follow from that as far as I am concerned and I would like to make them a part of the record.

First of all, you delay for 1 year a project that is very important, which you have just acknowledged. I think there is a consensus on this point here. The VA has already signed off on this project, both in their 5-year plan and also the Administrator's approval of the project submission. Is that correct that we are going to delay just for 1 year——

Mr. MOLLOHAN [continuing]. If we don't get funding in 1984?

Mr. SALMOND. Right.

Mr. MOLLOHAN. And you all have not asked for any funding in 1984?

Mr. SALMOND. That is correct because we had not completed the preliminary plans at budget submission time.

Mr. MOLLOHAN. I understand. We have already established that. A consequence of that is that we are going to pass up a wonderful opportunity to contribute to the economy of an area that has 20.4 percent unemployment. I think the last thing that we are looking at without coming down hard on this, but just reciting the facts, that we are going to get into a situation where we are going to be faced with increased costs. So it seems to me that the merit is compelling in this case, given your schedule and your acknowledgment that you are going to go on line with your final preliminary plans to get money in this fiscal 1984 budget for this project.

You have approved it. You agree it is necessary. You agree that you are going to come on line with your preliminary plans at the end of this fiscal year, maybe a month or 2 or 3, or maybe if you would push them a little bit, 4 months before and so that the only thing that is going to be holding up this project, crucially important to my area, I can assure you—there is no kidding about it when you go back every weekend and you are faced with 20.4 unemployment—it is crucially important to my area to have this project on board. Mr. Chairman, I just appreciate the opportunity to make this a part of the record.

Mr. EDGAR. We appreciate your questions.

Mr. MOLLOHAN. I hope this will help to get this project into the fiscal 1984 budget.

Mr. EDGAR. Let me just ask one question. Can you guarantee that the hospital will be in place before the 1990 census changes the census track once again?

Mr. ALVAREZ. Well, Mr. Chairman, I think that Mr. Mollohan's——

Mr. EDGAR. What was the answer to the question?

Mr. ALVAREZ. I didn't have an answer to your question. [Laughter.]

I think though that Mr. Mollohan's question illustrates a point, and that is the need to seriously consider the extension of the Advanced Planning Fund to cover working drawings. This is one of the issues that we are reviewing at this time in an attempt to resolve the particular type of problem that we face in various instances, such as Clarksburg. That is one point I would like to mention at this time.

Mr. EDGAR. I appreciate your comment and I also might suggest that somewhere in a jobs bill that is floating around is $75 million for maintenance and repair for VA and the priorities are being set. There is a great deal of effort in targetting that fund so that at

least 75 percent of the construction money gets targeted to areas that have high unemployment, and as demonstrated by my colleague, his area has significantly high unemployment. If all of the things that you suggest are true, this might be an area that you might want to discuss with OMB about a way to expend those funds in a constructive way. I just offer that as a suggestion.

Mr. MOLLOHAN. Mr. Chairman, I know you have given me too much time already. May I ask a very quick question?

Mr. EDGAR. The gentleman has 30 seconds.

Mr. MOLLOHAN. Thank you.

I understand that the project that we are looking at is approximately $27 million; is that correct?

Mr. SALMOND. It is in that range, yes.

Mr. MOLLOHAN. One more very quick question. I would like to inquire about the status of the ward renovation projects in the Clarksburg VA hospital and I would like to know whether or not they are on schedule, if you can tell me very quickly.

Mr. SALMOND. I can't answer that.

Mr. MOLLOHAN. May I have that question answered in writing from the VA?

Mr. ALVAREZ. We can provide that for you.

Mr. MOLLOHAN. Let me request it in that manner instead of taking up this subcommittee's time.

Mr. ALVAREZ. We can provide that for the record.

[Subsequently, the Veterans Administration furnished the following information:]

The Clarksburg, WV, project for Ward 3A will completed renovate this ward to provide patient privacy and a new medical gas outlet system. This project is included in our FY 1984 budget at an estimated cost of $1,300,000. On completion of Ward 3A, our plans are to completely renovate Ward 4A in the same manner in FY 1985 at an estimated cost of $1,400,000.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Mr. EDGAR. Mr. Penny.

Mr. PENNY. Thank you, Mr. Chairman, I think it is appropriate to follow up Mr. Mollohan's questioning on the scenario for one particular project to now ask about the policies and procedures for VA construction programs generally. We have testimony to be submitted to us by the Disabled American Veterans which includes a summary of the recommendations made by the President's private sector survey on medical cost control, and in that study they made specific statements about the VA medical system.

One of the conclusions in that study states that we need to simplify and streamline the extraordinary policies and procedures of the VA construction program.

What do you suppose the President's survey meant by that comment?

Mr. ALVAREZ. Mr. Penny, my understanding is that the draft report has not been released. It certainly has not been released to us.

Mr. PENNY. In the testimony from the DAV they indicated they had a draft copy of that report and that that was one of the recommendations. Have you seen that report at all?

Mr. ALVAREZ. We have not seen the draft report, and I understand that we are not scheduled to see it for a couple of weeks, at

which time we will be asked for our comments. I am not at all aware of what it recommends.

Mr. EDGAR. The question, I think, focuses on the word "extraordinary" that is in the draft statement, and perhaps either for the record or at a future hearing, you might try to define what they mean by that term, if, in fact, the term appears in the final draft.

Mr. ALVAREZ. Extraordinary.

Mr. PENNY. We would appreciate hearing from the VA if, in fact, that recommendation is still part of the President's report when it is placed in final form.

Listening to the dialogue between Mr. Salmond and Mr. Mollohan, I just thought it might be the right time to ask that question. But if you haven't seen the draft report, I will just respectfully request that at a time you have prepared a response, you make that response available to the committee.

Mr. ALVAREZ. Certainly.

Mr. PENNY. Thank you.

Mr. EDGAR. Thank you. Mr. Staggers?

Mr. STAGGERS. Thank you, Mr. Chairman, sitting way down here sometimes you wonder whether you will ever get to ask a question.

I share a lot of the concerns of my colleagues and sitting here in the committee, and as I indicated, sitting down here at the end sometimes you don't get to ask questions, but one thing I have noticed with some of the VA testimony is that it would appear that there is an acknowledgement of the problem, and I think that we all do acknowledge that. There is an acknowledgement by the VA that they are doing what they can and that they will try to do things better in the future and they have some good plans.

But it would appear that it is almost that we are trying to keep abreast of current demands and not really adequately preparing for the future. Am I getting that sense right, and if so, whose fault is it? Is it us sitting here or is it past problems?

Mr. ALVAREZ. Mr. Staggers, I think when we address the increasing needs of the future, we, of course, are looking at the requirements that will be imposed on the agency with respect to our veterans. We are seeing what is coming down the pike as a challenge of the future in addressing the needs of the aging veteran. I think that this situation, and Dr. Jacoby will support this, is not unique to the VA. This is a challenge that the nation will have to face. We are at the doorstep now of having to meet that challenge.

I do want to say, though, that given the VA's extensive efforts in this area, and such as our work in geriatric research and the work that is going on to address our nursing home care needs, the VA is taking the lead under the direction of our Administrator. He has clearly articulated the critical role the VA has in meeting the needs of our aging veteran population. In addressing this challenge for the future and meeting the needs of the next 10, 20, 30 years, you will see this agency in the lead. As our Administrator has said,"We are at the cutting edge".

Mr. STAGGERS. We can count on you to work on this?

Mr. ALVAREZ. We will be the prime lead in addressing this question in this country. Dr. Jacoby, can you amplify on that?

Mr. STAGGERS. OK. There is a statement in your testimony which concerns me also. It starts on page 6 and ends on page 7. It basical-

ly says that you believe that, and I quote, "It represents what we believe to be required to keep the VA infrastructure in an acceptable condition." What is an acceptable condition? It may be acceptable in a budgetary restraint which we are facing, but what about the veterans who are having to either live or stay in these facilities?

Mr. ALVAREZ. Mr. Staggers, I think that keeping "the VA infrastructure in an acceptable condition" means being ready to meet the needs wherever they may appear, wherever the requirements will be.

Mr. STAGGERS. And we are not being shortsighted with what we are defining as acceptable?

Mr. ALVAREZ. I think that it is acceptable to be able to meet the needs as the needs are arising and as we foresee the needs arise. Dr. Jacoby would you like to comment?

Dr. JACOBY. If I could address that in two different ways. I would like to take it from the clinical side of our needs and I think this is something that Mr. Alvarez was addressing, and then I would like to flip it over and on the basis of the clinical side, then look at it from the construction side.

On the clinical side we continually monitor the needs for the care of patients, including equipment, facilities, and things of this nature in order to provide quality health care in a cost-effective manner. I never like to get those two priorities mixed up because that has happened in the past. Now in providing quality care, believe me, the vast majority of our facilities are affiliated with universities and I think this assures us that we are providing high quality care. Staffs are interchangeable and so forth.

So when we talk about "acceptable" in my eyes we are shooting for the very best that we can provide. The word mediocrity doesn't exist in my vocabulary, and I hope we can get this across through our whole system. We are striving for the best we can in clinical care.

Now, if I turn that around and look at it on the construction side, I believe that there are enough requirements that we have in meeting various standards for accreditation and so forth, and then we set our own criteria and we are constantly evaluating what our criteria are in order to provide quality care. So the standards are there, and believe me, I don't think there is anyone in the VA's DM&S who will ever settle for something which is inadequate or that would be second rate for our veterans.

Mr. STAGGERS. Mr. Chairman, I ask unanimous consent for another 30 seconds.

Mr. EDGAR. I yield the gentleman another additional minute.

Mr. STAGGERS. One last question. There has been a lot of talk about contracting out of services. What is your position on that? Is that part of your plans for the future?

Mr. ALVAREZ. Bill, if you could address that.

Dr. JACOBY. Certainly, contracting is a part of our system. It is part of our system now. On almost any day we have approximately 1,000 patients in contract hospitals. We have 10,000 patients in contract nursing homes at the present time.

Mr. STAGGERS. I guess my question is, Do you see it as a replacement of the VA system as it exists now?

Dr. JACOBY. Absolutely not. Our position is that we will maintain a health care delivery system independent for the veterans.

Mr. MURPHY. Mr. Staggers, as the law now stands, we could not contract out direct patient care or activities incident to direct patient care.

Mr. STAGGERS. Thank you.

Mr. EDGAR. I yield to Mrs. Johnson.

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

Mr. EDGAR. Mrs. Johnson, would you yield just a moment to Mr. Mica?

Mrs. JOHNSON. Yes, certainly.

Mr. MICA. I am sure the Chairman will yield you additional time, if necessary. I must leave. I just wanted to make this statement for the record, gentlemen, it will be legislation, you have probably seen a copy of it, to authorize a new hospital for Florida, and I do support the actions of Mr. Mollohan and others. Many of us from Florida supported that jobs bill to provide facilities and help for veterans all over the country. Not a single city in Florida qualifies for that 75 percent.

So we are trying to help all over the country, but we do need some help in Florida.

Thank you, Mr. Chairman. Thank you, Mrs. Johnson.

Mrs. JOHNSON. Thank you. I would like to pursue ever so briefly the issue further of the obligation of the system to provide for its increasing, aging population and how you intend to do this.

As the Congressman representing the Newington Veterans' Hospital in Connecticut, I am deeply concerned about your plans to convert that 100 percent to long-term care. In my estimation that will not serve the acute care needs of my veterans in the region. As I listen today and as I read the testimony in preparation for this hearing, I wonder why you are not converting acute care beds throughout the system to long-term care so that the ability to fulfill the need for long-term care is distributed in the same manner as acute care capacity.

Mr. ALVAREZ. Mrs. Johnson, Dr. Jacoby will address that very adequately.

Dr. JACOBY. Let me address the Newington issue. You are absolutely correct. In the original submissions of the MEDIPP plans which we got in November there was a proposal to redirect the mission of the Newington facility to an extended care facility. This plan has not been approved by the Chief Medical Director and I can only assure you that it is getting some careful attention and discussion within DM&S at the present time for many reasons. No. 1, I think we recognize what the requirements are in the area and we also recognize the dependence of the medical schools in the area on that facility.

So that decision has not been made, nor has a recommendation been made to the Administrator. As far as the entire system and looking at the conversion of beds to extended care beds, it is done on a national basis and we have many facilities, particularly those which are near VA tertiary care facilities. Where it seems to be a reasonable thing to do, to change the mission of that hospital, use the tertiary care facility for the acute backup and have that facili-

ty as the extended care hospital. We are considering mission changes. This is a national policy not strictly within one area.

Mrs. JOHNSON. Thank you. I appreciate your comments and I appreciate that you are reconsidering that decision. I know that the medical director doesn't support it. I can tell you that the veterans don't support it either and I would, before you come to a final decision, appreciate the opportunity to sit down with you and whomever else to review in detail the considerations, the components of your decision, because I know that for my veterans it is important to retain an acute care capacity. The location of the veterans hospitals in Connecticut means that those from the western corridors and eastern corridors have great distances to travel and such a radical change in care facilities would be certainly detrimental to the interests of the veterans in my region.

Also, there are a couple of other points that I would like to hit on. Over the past few months, there have been various projects that have been awarded at bid prices substantially below the original projection. At least that is my understanding. Is that a correct statement and if so, why is that occurring?

Mr. ALVAREZ. Mrs. Johnson, your statement is correct and it is a sign of the times that we are seeing this. I will ask Mr. William Salmond, of the Office of Construction, to comment further. We have been seeing lower than anticipated bids on a national scale for the past 1½ years, but much more so in the last few months.

But how that will develop in the future and how things will turn in the future as the economy improves remains to be seen. Bill, would you amplify on that?

Mr. SALMOND. Yes, the projects that are going out for bids now obviously were in budgets a year or two earlier. At the time when those budget numbers were prepared, we were seeing a double-digit escalation and therefore we had to allow for this in our budget estimates. Since then the economy took quite a sharp tumble and the marketplace today is very depressed. The bidding that is going on for projects is very fierce and the contractors are slashing their profit margins, their discount margins and everything else just to get a job to keep their money flowing. The VA, and not only the VA but every contracting agency in this town is experiencing the same situation.

Mrs. JOHNSON. That does not in any way represent a reduction in standards or goals?

Mr. SALMOND. Absolutely not.

Mrs. JOHNSON. On March 3 this subcommittee conducted a hearing on the subject of the provision of health care to female veterans. At that time there was a difference in opinion between the Department and the women veterans as to the availability of both privacy and adequate staffing to meet the health care needs of our female veterans.

I want to know from you, in all of your construction plans are you planning for in a very concrete sense, the increased number of female veterans that you are required to serve in the coming years.

Mr. ALVAREZ. Mrs. Johnson, the female veteran issue and the projected number of female veterans are very significant considerations in our MEDIPP planning process, and, at the direction of our Administrator, in the design and planning of our facilities.

He is forming an advisory committee for female veterans to stay on top of the issues. He is very much interested in, and we are very actively involved in, all aspects of the female veteran issue at this time.

Mrs. JOHNSON. Would you submit to this committee in writing details of how you are planning to meet those needs. What are your construction plans? How have they been altered to meet those needs, because in that hearing there was a very clear gap between what female veterans were experiencing and what the Department, through its administrative chain of command was hearing from itself about what it was providing. That concerns me.

It is not surprising that a bureaucracy that has a clear mission statement about serving all veterans might believe that it is indeed doing that. But when there is clear evidence that those who are supposed to receive those services say they are not receiving them, then I think we have to deal with that reality of the difference in perspection.

So I would like at some time not a long treatise, but a concrete statement as to how in the various projects that you have on line you have specifically addressed this growing need.

Mr. ALVAREZ. Mrs. Johnson, we will be happy to provide the information to you for the record; however, this is the very issue which we will be testifying on today, and Dr. Jacoby and members of his staff will provide, I believe, the data that you are interested in.

Mrs. JOHNSON. Thank you.

Mr. ALVAREZ. Bill, do you have anything to add?

Dr. JACOBY. There isn't any question that sometimes the view from Washington looks different from the view down in some other area, and I believe that is the fundamental basis of why Dr. Custis initiated Medical District Initiated Program Planning. In other words, "Let's stop planning from Washington and let's start looking from the grassroots up. Let them do the planning and feed it into us."

In regard to female veterans, we, in January put out again another circular, with two important parts as follows: No. 1, it gave direction as to the providing of care for female veterans, particularly, in providing gender-related care for our veterans.

All of our facilities will be required to submit a plan to us by June as to how they are going to care for gender-related illnesses. We encouraged that it be done in-house and not only by contract or fee. So in June we will have a plan as to how this is going to be done.

Also part of that circular was a requirement to review their physical plant deficiencies and develop plans for correction. We are right now aggressively pursuing correction of those deficiencies.

Mrs. JOHNSON. Thank you, Dr. Jacoby and thank you, Mr. Chairman.

Mr. EDGAR. Mrs. Johnson, I really appreciate your asking the question relating to the women's hearing that we did have. Perhaps we have invented a new term with your request and that is that we have environmental impact statements. Now we should have a woman's impact statement for each construction project. I think that makes some sense.

Let me ask just a couple of questions. I beg your indulgence. You did a great job in putting together this little map, which I think someone down in the depths of the VA put together. I have a rather naive question about the map. I have been sitting up nights reading it and studying it.

I was intrigued at something and maybe it has no merit in terms of process or workability within the VA health system, but I was struck by a very simple thing in terms of the six medical regions. I know they are drawn by population. But I was wondering about the justification for having the six medical regions outlined the way they are. For example, from Fort Harrison, Mont., up here down to Houston, Tex., seems to me an incredibly long distance in terms of that region. We then go from Seattle, Wash., down to Big Spring, Tex., kind of a banana-shaped region. I was chair of a group called the Northeast-Midwest Congressional Coalition and we had three sections of the country, the New England, the Mid-Atlantic and the Midwestern States devised into 18 States which have about 45 percent of the population. In dividing it up the way we did, we could expand and include other States like Missouri and West Virginia in our regional analysis, if we wanted to. It was compact and the regions had a sense of being a region.

I am not sure that Fargo, N. Dak., and Texas have the same demography and some of the same interests and needs. Does anybody remember when this was put in place and what the regional analysis is?

Mr. ALVAREZ. Mr. Chairman, I certainly do not remember it, but I think that Dr. Jacoby would.

Dr. JACOBY. The only thing I could say, Mr. Edgar, is that when I first looked at it I thought it was done to confuse me. But fundamentally, there was a basis for it.

We started with the distribution of veteran population and then we took the number of VA facilities within that area, broken down into districts; we then put the districts together into regions so that there is a fairly decent balance, between the number and types of facilities.

Now the flow of patients was also somewhat important. Patients from Sheridan, Wyo., have a tendency to go to Salt Lake City, not east. The same thing happens in west Texas. Those people move east when they have to go up to a tertiary care facility.

So fundamentally then, it was done on the basis of total demographics, number of facilities in the area, the number of districts and then, finally, how veteran populations move themselves to our various facilities.

Mr. EDGAR. Really, your concern was more by districts and then districts kind of evolved into regions?

Dr. JACOBY. That's correct because the whole process was designed so that the VA DM&S would be a decentralized system. The basis of the system is the individual facility. We then organized those facilities into districts so that there would be some relationship to providing for the total quality and the extent of care within that area. Then we organized districts into regions to reduce the span of control. I know some of you particularly Mr. Wilson and Mr. Castel remember that for a time in the past DM&S went into a functional organization in which line authority came down to one

person and that was totally unworkable. So we decreased the span of control and I believe we have a much better managed system in DM&S which includes the hospital, the district, the regional concept, and finally the central office level of line management.

Mr. EDGAR. I have no problem with the decentralized system. It just seems to me that perhaps in second looking at your regional breakup that, for example, Iowa would rotate a lot more closely to Chicago and to the Midwest than to the Southwest.

Let me ask you a couple of other questions. By the way, I want to thank you for the map. I will continue to study it. If I find any States missing, I will tell you.

We had talked about the women's issue and I just wanted for the record to ask if in the MEDIPP process women are included as well in terms of analysis?

Mr. ALVAREZ. Mr. Chairman, the women veterans are considered right along with all veterans as part of our demographics and as a part of all the considerations when constructing a facility.

Mr. EDGAR. In your opinion, by the year 2,000, as you come to testify before this committee, given present rates of construction, present rates of rehabilitation, present rates of replacement, will we have adequately addressed the needs that you project 5 years, 10 years, 17 years down the line to the year 2,000?

Mr. ALVAREZ. Well, Mr. Chairman, in my opinion, the challenge that we face is a great one, but I feel confident that the VA, taking the lead in meeting those challenges, will be meeting the needs that we will face in the future. This is the direction and the course that the Administrator is setting. He has purposely set this course.

Mr. EDGAR. Do you have a "foresight office" in the VA to look at long-range planning beyond the 5-year plan, that is, a vision of the future near-term for the agency?

Mr. ALVAREZ. Strategic or long-range planning is done in conjunction with our Office of Program Planning and Evaluation, and also within the Department of Medicine and Surgery. Dr. Jacoby can better address the work that's being done in meeting those needs in the field of medicine and surgery. Bill?

Dr. JACOBY. The program planning and analysis complex, which is our planning area, is a separate program headed by Dr. Murray Mitts, who does look at our long-range planning. They do their projections for 1990, 1995, and the year 2,000. So in answer to your question, yes, we are looking at it and studying it.

Mr. EDGAR. A few weeks ago when I visited the VA Central Office I raised a question about the $75 million that was committed in the jobs bill for the VA and whether or not the VA had been discussing ways to use those funds in a timely manner to do a major investment for the VA, but also attack the unemployment problem.

Has the VA decided how these funds will be used?

Mr. Chairman, those funds are maintenance and repair, M&R designated funding. Bill?

Dr. JACOBY. The legislation, for instance, on the Senate side, doesn't direct that those funds be directed to areas of unemployment. I believe that stipulation has not yet been made.

Mr. EDGAR. If I could interrupt just a moment. Senator Specter from Pennsylvania was able yesterday late afternoon to put a per-

missive amendment on the bill in the Senate similar to the Edgar amendment, which does give you permission to target the funds to areas of high unemployment rather than mandatory as my amendment suggested.

Dr. JACOBY. What we were planning to do, through available statistical data from the Bureau of Labor Statistics was to look at what our needs were and the unemployment throughout the country and try and direct those M&R projects to areas where they would meet our needs and at the same time accomplish what you and the Congress would like to do in having a significant impact on unemployment.

Mr. EDGAR. It seems to me that there will be quite a bit of discretion in use of the funds, but I think the intention on both sides of the Congress is that those funds leverage the most employment possible, and still make an investment, in rehabilitation and reconstruction.

Dr. JACOBY. I can assure you, Mr. Edgar, that we have enough projects which are significant or needed within our facilities to account for the $75 million. We might also point out, because there was a discussion a little bit earlier in regard to the project in West Virginia at Clarksburg. That project would be a clinical improvement project of an entirely different category and not within the purview of the maintenance and repair program.

Mr. EDGAR. Let me shift gears a little bit. Public Law 96-330 authorized the VA to establish 15 geriatric research and clinical centers. You have established eight and the plans are in the work for nine, if I am not mistaken. Is that correct?

Dr. JACOBY. That's correct, sir.

Mr. EDGAR. One of the purposes of the GRECC program was that the centers be located in areas where research and treatment could be done on geriatric patients in a creative way in an area where the VA has neighboring health facilities in the private sector that could help in that research. The private medical community in the Philadelphia area has already become well-known in organizing and advancing the study of geriatrics and aging process. It would seem to be only logical that the VA should participate in this effort. I would considerate it a possibility in the work that is being done to renovate and expand the nursing facilities for Philadelphia and the clinic facilities, that the possibility of a geriatric research center in that area might make some sense, given the location of five major medical schools, including the University of Penn, Hanahman and Jefferson, Einstein, and others.

I am not going to ask you specifically whether or not you have planned for that, but I would urge that you take a look at that possibility as a possible location for one of the remaining geriatric locations as we proceed with that construction project. Now that the author of that program is the Secretary of Health and Human Services, I am sure she will continue to look over our shoulders to make sure that we care for the intention of the legislation that put into place those geriatric centers.

Do you have any comment to make?

Dr. JACOBY. No. We certainly appreciate your comments and in our future planning for GRECC's we will be considering those

areas where we think that they will be able to accomplish their mission.

Mr. EDGAR. Thank you very much. We have several questions that we will furnish to you for the record and we would hope that you would supply the answers to them or ask your staff to respond.[1]

I appreciate your patience this morning in taking the questions. Some of the members who have shown some interest particularly the newer members may be calling and contacting you directly about specific questions. We are planning to begin in April our series of field hearings starting first in the Pittsburgh, Erie, Butler, Pa., area and moving throughout the Nation. We urge your strong participation as we learn more about the health care system.

If there are changes in your construction priority process and plans, we would appreciate it if you could keep the committee informed.

The committee will stand in recess for 10 minutes to respond to this vote and then we will return to hear the rest of the witnesses.

[Brief recess.]

Mr. EDGAR. The hearing will now reconvene. Thank you for your patience. We have just voted on the nuclear freeze resolution and I am sure we will all be interested in hearing the outcome of that. That should keep us from having additional votes for a while.

Our next witness will be Mr. Ellsworth Sharpe, the national president, Blinded Veterans Association.

Mr. Sharpe?

Thank you for coming this morning. Your full statement will be made a part of the record. We invite you to summarize your statement for the record and we appreciate your testimony.

STATEMENT OF ELLSWORTH L. SHARPE, NATIONAL PRESIDENT, BLINDED VETERANS ASSOCIATION; ACCOMPANIED BY DR. GEORGE STOCKING, LEGISLATIVE COMMITTEE CHAIRMAN AND SUMNER VALE, ACTING EXECUTIVE DIRECTOR

Mr. SHARPE. I am Ellsworth Sharpe and this is George Stocking on my left. He is the Legislative Committee chairman. On my right is Sumner Vale, our Acting Executive Director.

It gives us great pleasure to testify before this subcommittee today. We realize that the subcommittee has a tremendous responsibility to maintain the health care of America's veterans. Also, we would like to congratulate Representative Edgar for being named chairman of this subcommittee. Also, Mr. Edgar, I would like to congratulate you for your fine appearance on the MacNeil-Lehrer Report the other night.

Mr. EDGAR. Thank you.

Mr. SHARPE. Recently, the VA presented a study which was entitled "A Plan for the Delivery of Services to the Veterans of Puerto Rico and the Virgin Islands." During this testimony by the VA and also questions which followed by members of this committee and by other veterans groups, there were no real surprises. The surprises, however, were those things which were left out.

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[1] See p. 61.

The things I would like to discuss were the things left out, and they were the needs of the blinded veterans of those islands.

According to our records, the VA has about 600 blinded veterans on their rolls on the islands. The rolls are relevant to receiving compensation and pension. Our experience nationwide has taught us that if there are 600 people receiving compensation and pension for blindness, there are approximately 1,200 in need of services.

When a veteran goes to blind rehabilitation, often he has to leave his home and familiar surroundings and leave his family for a period of time. The Blinded Veterans Association has a program, our field service program, where we go out and we try to convince blinded veterans of the value of participation in a rehab program—how this will improve his quality of life.

Some of the problems in Puerto Rico are even more difficult. Puerto Rican veterans have to go an even longer distance to receive training from the VA in blind rehabilitation, but also they have to go not only to a different area with different climate and customs, but also where they speak a different language.

The customs of the Puerto Rican people do not encourage self-sufficiency in their handicapped people. We believe that self-sufficiency is necessary in order to obtain the skills and attitudes necessary for a blind person to live with his handicap.

The problems in Puerto Rico are even more devastating when you consider the fact that not only is there no VA facility for blind rehabilitation located on the island, but that also there are no accredited civilian agencies which do that type of work.

The VA has had a blind rehabilitation clinic in their 5-year plan for the past several years. However, from year to year, it loses priority and slips to the bottom of the list and it has not yet received initial approval. Initial approval from the VA, however, 1 day doesn't mean the blind rehabilitation clinic will be established the next day. Past experience, for example, the Southeast Rehabilitation Center in Birmingham, Ala., indicates that this is true. Birmingham's center was first approved in the late 1960's. It opened last October 1982.

The VA has determined that a 10-bed facility would be appropriate for the Puerto Rican area. This 10-bed facility would require 8 people to staff it. Therefore, the VA has completed a study already to determine the need for such a facility and VA also has determined the staffing required for this facility. We in the Blinded Veterans Association believe that the Government should take the steps necessary now to establish such a clinic.

George?

Dr. STOCKING. Mr. Edgar, I would like to just amplify some of the things that Mr. Sharpe said. One of the major problems is the cultural aspect of this situation, the fact that the Latin-speaking people have to come to an area where they don't have Spanish spoken, where they have a different cultural approach to the needs for rehabilitation. It is really a desperate need that this type of facility be available in the Puerto Rico VA Hospital. It has not been planned yet and we urge that we put that in the program and that the construction of that facility have a priority.

Mr. Edgar, Thank you very much.

Does that complete your statement?

Mr. SHARPE. Yes.[1]

Mr. EDGAR. I would like to say that I really appreciate the fact that you have focused in on the health care need particularly for Puerto Rico and the Virgin Islands for specialized facilities for blinded veterans. I have on my schedule an opportunity to visit with you a little later today and I hope that's also on your schedule for later today. I don't have any further questions at this time. I again thank you.

Mr. SHARPE. Thank you.

Mr. EDGAR. I would like to move to the Disabled American Veterans next. We are jumping over a couple of witnesses, but there is a time factor involved with this witness. Mr. Charles Joeckel, Jr., deputy national legislative director, Disabled American Veterans. We welcome you and invite you to summarize your testimony. Without objection, your full statement will be made a part of the record.

STATEMENT OF CHARLES E. JOECKEL, JR., DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. JOECKEL. Thank you, Mr. Edgar. Let me thank you for moving me up on the schedule here this morning. I do have some engagements this afternoon and I appreciate that very much and the cooperation of my friends in the other veterans organizations.

You have my full statement. I believe it speaks for itself. One thing I did want to clarify in my statement is that we have requested full funding of the VA's request for construction projects. I wanted to clarify that where the committee thought it would be best to authorize projects we would certainly be supportive as long as all the money is utilized for VA construction programs. We believe that certainly there is a need to improve the medical care system within the VA.

The overall sense of my statement deals with our critical need for nursing care beds in the system and to maintain acute-care bed levels to meet the needs of Vietnam veterans as they are also aging. The average age of the Vietnam-era veteran is now 35 years old. By the year 2000 they will be 53, on the verge of needing much, much more acute care and long-term care.

I would like to address one of the questions that Mr. Hillis raised to the VA regarding the utilization of beds in the system and closure of beds with respect to fire and safety regulations.

The VA in their response bandied around several figures totalling, I believe, 9,900 beds. Yet our reports from our service officers around the country would show that throughout the system there are closures of entire wards and indeed sections of hospitals. My testimony asks that the VA utilize what we call "dark wards" now, to convert them to long-term or extended care beds within the particular hospital.

Appended to my statement is an article which appeared in the New England Journal of Medicine telling why acute-care hospitals should look into the extended care area and how it can be cost effective.

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[1]The prepared statement of Mr. Ellsworth Sharpe appears on p. 99.

We comment briefly on the MEDIPP which we support in the sense that the needs of the hospital system, from the field station point of view, will be helpful to the central office. We do not agree with the way that the VA directed the various districts to respond to the MEDIPP program, but in the future I think that it will be helpful to the VA.

In addition, I comment that we have received the draft copy of the President's private sector survey on cost control. These are just a few of the recommendations contained in that report. It is filled with many other recommendations to which the DAV and I am sure many other veterans organizations would be opposed.

We are particularly opposed to the idea of contracting out the operation and construction of facilities to the private sector because we believe that in the long run the VA should be involved in the continuation and overall care to meet the needs of all veterans, those who are aged now and those of us who 30 years from now will be aged.

That concludes my oral remarks, Mr. Chairman. I would be pleased to answer any questions.[1]

Mr. EDGAR. On page 7 of your testimony you talk about the President's private sector survey on cost control and the fact that you have a draft copy. Would it be possible to make a copy of that available to this committee at this time?

Mr. JOECKEL. In anticipation of that, I have it with me and would be delighted to give it to the staff.[2]

Mr. EDGAR. I appreciate that. I was a little bit surprised the VA did not have knowledge of some of the recommendations that you reference in the report. I do know that the information has been available and is available and with a copy of that we will consider the possibility of having some direct hearings on the recommendations that are being made by that particular group, because they do have an impact on what we do in the VA health care area.

Do you have any idea as to what they mean on the bottom of page 7, point 3 under conclusions, what they mean by "extraordinary policies and procedures of the VA construction program."

Mr. JOECKEL. Well, addressed in the report is a comparison of the Hospital Commission of America and how they operate a $200 million program of construction with 50 employees. They compare that budget and number of employees to the fact that the VA construction program has nearly 900 employees. Also, they are talking about the area of DM&S which is responsible for construction, and the Office of Construction not necessarily getting together and coordinating a plan which would suit the veterans' needs over 5 years or in the future. Their recommendation, of course, is to eliminate the two different offices and to coordinate those efforts closely in addition to eliminating employees.

Mr. EDGAR. I really appreciate your submitting that for the record. I don't have any specific questions. Your testimony is very thorough, some of your common views, and hopefully, over the next course of months we can confront the VA health care system on a number of the issues that you raise.

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[1] The prepared statement of Mr. Charles E. Joeckel, Jr., appears on p. 104.

[2] Retained in committee files.

Mr. JOECKEL. Thank you, Mr. Chairman.

Mr. EDGAR. Our next witness will be Mr. Harris B. Stone, national executive director, Jewish War Veterans.

We appreciate your coming today. The Jewish War Veterans have not testified for some time before our committee and we appreciate your presence here today and your ability and willingness to testify on this subject. The full text of your statement will be made a part of the record.

STATEMENT OF HARRIS B. STONE, NATIONAL EXECUTIVE DIRECTOR, JEWISH WAR VETERANS

Mr. STONE. Mr. Chairman, thank you very much for your kind consideration. It is really a privilege for us to be here. I regret that our national commander, Stanley Zwaik, called me just late last night and said he couldn't be here. I am the present national executive director and have with me our public relations director and assistant for research and operations and I would particularly like to recognize, Mr. Chairman, our department commander from Maryland, who is Mr. Bob Arzt.

Mr. EDGAR. I might say before you begin for the record, one of your members, Stanley Rosenberg from the Philadelphia area that everybody knows spends a great deal of time educating me on veterans issues. Stanley has been a friend of mine for the last 8 years and has done a really good job in the Philadelphia area. His dramatics and way of speaking have caught the imagination of a lot of people at hearings in the Philadelphia area. I just want to recognize the fact that he is a distinguished member of your organization.

Mr. STONE. He certainly is, and also he is our national service officer and a very good one. He has been of great assistance to us.

I guess our concern, Mr. Chairman, is the continuing deterioration and increasingly outmoded facilities that are occurring in the overall health care system. You know that many of the hospitals were built in World War II and they are still in use. So are some of the buildings that were constructed at or before the turn of the century. We could go on and on and review these, but these do dominate our concerns over what is happening and what will transpire as time goes on.

We feel that the VA medical care and medical construction budgets must be given top priority and top consideration over the next two decades. While the VA has never been expected to care for all veterans and we do not ask for any change, and I want to emphasize that, we do ask that the VA continue the mandate under which it has operated for these many years.

They must plan for the health needs of the service-connected, disabled, and needy veterans who are growing older. A constant and substantial investment in the capital plant of this system must be made now if our Nation is to meet its minimum responsibilities.

Now, I do point out that, I am a scientist and engineer, that the technology is moving very rapidly and all too often it has not kept pace as far as our medical facilities available to veterans are concerned. I would ask that this be particularly noted, because that is where the upgrading is really needed.

I was pleased to see the budget proposal contains funding of long-delayed and long-needed replacement hospitals at Minneapolis, at Gulfport, Biloxi, Miss., facilities, numerous outpatient, clinical and general improvements at hospitals and facilities throughout the system.

We are supportive of those budget increases, especially in funding over last year's level, for the construction of the new nursing home care units and of the conversion of the existing VA facilities nursing home care units. I think our testimony shows what will be added and we see that the sufficient funds be continued for this.

The thing I would like to emphasize is that we are concerned over the apparent lack of funds in the fiscal 1984 budget proposals for construction of new domiciliary facilities or remodeling or renovating existing ones.

This would mark the third fiscal year in a row in which no funds were provided for new construction in this area. Now we believe that substantial improvements in the VA's domiciliary system are needed. Most of the VA domiciliaries are 50 years old. Many domiciliaries do not meet current standards for fire safety and still maintain simple, barrack-type wards with insufficient privacy and communal facilities. The toilet facilities are horrible. I personally witnessed those when I served as national commander and it was quite shocking to see that we had people being cared for that way in this modern day and age.

We believe that the number of aging veterans, particularly those with insufficient social or family resources to meet the minimal care needs, will increase in the next 20 years. We urge this subcommittee to monitor closely the needs of veterans for this type of care, and we urge you to consider providing additional funds in this area of the medical construction budget. We recommend it be considered now.

Otherwise, I could say we are generally satisfied with the VA's current 5-year construction program. We consider the plan to be a fair and reasonable attempt to establish priorities for construction and modernization throughout the VA system and suggest that the VA medical construction budget needs in each fiscal year be continued. There are some deficiencies. We feel that this plan does not adequately address the present and future of medical care needs of veterans in the State of Florida and in the city of Baltimore, Md.

A recent VA study, entitled the "30-Year Study of the Needs of Veterans of Florida," projects a need in 1990 for 1,019 more inpatient beds and 922 more nursing home beds than were active in fiscal year 1981. According to our information, neither construction in Florida since that date nor future construction that is called for in the plan, will be sufficient to meet the entire projected increase of those beds.

We are concerned that the present and future construction budget proposal, based on this plan, may not take these needs into account. In addition, we know that the plan considers the Baltimore VA medical center to be one of the 10 medical centers most in need of construction, replacement or major modernization in the VA system. As you know, significant plans for the construction of a replacement hospital in Baltimore were underway and the con-

struction funds were actually appropriated before this administration canceled the project in 1981.

Despite this existing groundwork, no timetable has been set for the inclusion of funds in this or future year's budget either for continued planning or construction of necessary facilities in the Baltimore area. We urge that you take the needs of these areas of the country into account when considering this VA medical construction budget in this and future years.

Thank you very much.[1]

Mr. EDGAR. Thank you very much for your testimony. I can assure you as long as we have Dan Mica on the subcommittee Florida's needs will be raised at each hearing and we will pursue it as aggressively as we can. We had some testimony earlier on the issue of Baltimore and we share your concern that that project come to life again.

One issue that you raised that no one else has raised is the issue of domiciliary care and we want to assure you that as a result of your testimony we plan to submit to the VA a question asking them to give us their plans for the future as it relates to domiciliary care both short term and long term. We think that is an important issue which you raise.

We also want to welcome you back in terms of your testimony and we know that you will want to testify again at future hearings on other subjects before this committee. We welcome that from the Jewish War Veterans group.

I know it is tedious to put testimony together but it is important for us to have you do that work asking your membership and people out in the field questions so that we can more fully understand what the larger needs are. So therefore, we are grateful to you for taking that time and that energy at this point.

I don't have any specific questions to ask you. Your testimony really speaks for itself and we thank you for coming.

Mr. STONE. Thank you very much, gentlemen and Mr. Chairman.

Mr. EDGAR. Our next witness will be Mr. Frank DeGeorge, associate legislative director of the Paralyzed Veterans of America.

Mr. DeGeorge, I want to welcome you here and compliment you on your statement. Your book will be made a part of the record. I think there's some 40 pages of testimony that you have prepared in great detail on this subject and I know the members of your organization have a great concern and love and hope for future improvements at the veterans health care facilities across the country and that is the reason for your continuing great work.

Your full statement will be made a part of the record and we invite you to summarize it at this point.

STATEMENT OF FRANK R. DeGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. DEGEORGE. Thank you, Mr. Chairman. As you pointed out, the PVA is never at a loss for words, and as you have said, I hope they do prove to be meaningful to you.

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[1]The prepared statement of Mr. Stanley N. Zwaik appears on p. 120.

Before I begin, the Paralyzed Veterans of America want to extend their congratulations and best wishes to you as the chairman of this subcommittee and to welcome—and extend the same congratulations to the new members of the subcommittee.

Mr. EDGAR. Thank you.

Mr. DEGEORGE. Of course, our effort is to work and look forward to reinforcement in working with the entire subcommittee. And I must not be remiss in stating that a sincere expression of appreciation is also extended to your staff for their able capabilities, cooperative efforts, and certainly their support.

Presently, the Congress and the administration are legislatively addressing their growing concern over the plight of unemployed citizens in this country, a concern which PVA shares. The jobs bill, H.R. 1718, includes serious consideration towards stabilizing many of our Nation's decaying structures such as highways, bridges, and mass transportation, while also providing new employment opportunities.

The VA health care facilities, like the Interstate Highway System, are part of the Nation's assets and both were designed to contribute to the national defense. It would not be inconsistent with the purpose of a restoration employment measure to include VA facilities as objects for repair, as it would be giving needed attention to the urgent situation which surrounds many deteriorating VA facilities.

The assigned purposes of such VA structures are to provide medical care for the increasing number of veterans who are in need of health and medical services in an unprohibitive manner.

The Brockton, Mass. VA Medical Center and the Spinal Cord Injury Center located there are examples of the decay which PVA has observed within the VA health care system. The Spinal Cord Injury Center is in need of renovation and it is filled to capacity while other spinal cord injured veterans await admission. Yet, the Veterans' Administration speaks of reducing spinal cord injury beds largely because of the facility's poor conditions and the major renovations which would be required to make the SCI facility truly operative.

Numerous VA facilities need prompt attention and many others such as Brockton are located in geographical areas where capable workers are unemployed. It is only reasonable that the VA medical and health care facilities be provided in any restoration employment measure created by this Congress.

PVA would support any reasonable measure which included this provision. We also support the acceleration of new construction projects which have already been identified as required by the Veterans' Administration. A long-term care spinal cord injury care facility at the Hines VA Hospital in Hines, Ill. should clearly be considered if there is a program of accelerated construction.

This project is discussed at length in our submitted testimony and the VA's experts have long agreed with PVA that construction must begin soon if the needs of spinal cord injury veterans in that geographic area are to be met.

PVA trusts that this committee will work actively to have the renovation and construction of VA medical and health care facilities included as part of the Federal infrastructure which is to re-

ceive needed attention. The above VA hospitals are only but a few examples which are in need of such consideration. One would benefit from restoration and the other from accelerating the VA's construction program.

I would like to now address some of the specific needs of the spinal cord injury service. The VA and PVA have been working closely together to study the demographics of spinal cord injury veterans in an attempt to more accurately identify the location of such veterans and to examine their usage of the VA health care system. Whether or not there is a change in the construction process, there are certain requirements of the VA's spinal cord injury system which must be addressed. These needs have too often been ignored in the past.

However, there is newly acquired data upon which the VA can accurately plan the construction of spinal cord injury acute and long-term care projects. Based on demographics, the need for constructing new acute care spinal cord injuries centers in the Southwest are clearly identifiable. There is a need for establishing additional spinal cord injury centers in the Southwest because of the great distances separating spinal cord injured veterans from existing centers and because of the heavy usage already being placed on the centers which surround the vast region.

Medical region 6 includes two spinal cord injury centers from western Texas through California. Medical region 5 contains only one spinal cord injury center which is in Houston, Tex. North of Houston there is not another spinal cord injury center in the United States. Succinctly, veterans residing in the Southwest must travel considerable distances for spinal cord injury care only to arrive at VA centers which are already filled to capacity.

PVA's highest priority for the establishment of a new spinal cord injury center is in Dallas, Tex. Demographics support establishing a spinal cord injury center in Dallas, Tex. The Houston, Tex., spinal cord injury center, while it may appear to be ample for the State of Texas, it is not. The Houston facility's occupancy rate remains near 100 percent according to VA reports and PVA's observations. VA reports for the period ending May 31, 1982, show that at Houston there was an average daily census of 21 patients for 22 beds, with 1 bed remaining for emergencies.

In addition to this daily census, eight other SCI veterans were hospitalized in nonspinal cord injury beds. In short, this 22-bed facility is treating, on the average, 29 veterans at a time. The Houston VA Spinal Cord Injury Center is not of adequate size to meet the needs of spinal cord injured veterans in Texas. The Houston Spinal Cord Injury Center, at best, barely meets the needs of spinal cord injured veterans who live in the immediate vicinity of that city.

Dallas has a general VA medical center. It treated more spinal cord injury patients than any other nonspinal-cord-injury VA hospital in the VA system between 1976 and 1982. The addition of a 60-bed spinal cord injury center in Dallas would meet only the needs of spinal-cord-injured veterans in the catchment area who are being treated in general hospitals. For it to address the continuing influx of spinal-cord-injured veterans to the Southwest, the facility would need considerably more than 60 beds.

To further alleviate the critical bed shortage of spinal-cord-injured veterans in this area, PVA's second priority is the establishment of an SCI center in San Antonio, Tex. The almost nonexistent availability of beds at the Houston Spinal Cord Injury Center and the size limitations which restrict the recommended expansion of the Dallas VAMC, all necessitate the need for this center.

The San Antonio VAMC currently has an existing structure that could quickly, at a relatively small cost, be converted into an SCI center. The utilization of station funding could accelerate the creation of a center at this facility with no significant effect on the VA's construction budget. It is important to note that on occasion station funding has been accelerated and/or increased. It is known that station funding has been increased as high as $6 million.

An SCI center at San Antonio, Tex., could be completed for about $4 million. Acceleration of this potential project would be cost effective because there is a structure already in place that can serve SCI veterans. It could do this in the very near future. It is estimated that within 3½ years a VA SCI Center could be operational at San Antonio.

The San Antonio, Tex., VAMC has station funding for $2 millon; a commitment for 2 fiscal years would mean $4 million and the ability to complete a needed SCI center in a considerably short period of time. Additionally, PVA, in site visits to the San Antonio VAMC, has found the staff willing and enthusiastic in developing an SCI center.

Similarly, the demographics and statistics reflect the need for additional SCI centers in the Southwest in addition to those in Texas. PVA's longer statement examines this point.

Finally, special attention should be given to the exigencies of aging veterans as PVA has a special concern for the requirements of aging-spinal-cord injured veterans. The expected continuing increase of migrating and aging-spinal-cord injured veterans to Sun Belt States requires attention and subsequently action to provide for their health care needs.

The needs of long-term care for spinal-cord-injured veterans, although briefly addressed, are included in PVA's statement. Again, the demographic information reflects that long-term care facilities are also urgently needed in Houston, Tex., Tampa, Fla., as well as in Hines, Ill.

Mr. Chairman, I trust that each member of the committee and the committee's staff can take the time to examine the summarized demographic information contained in PVA's statement. That information supports each request made by PVA in its desire for additional acute-care and long-term-care facilities.

This, therefore, concludes my testimony on behalf of the Paralyzed Veterans of America. Thank you.[1]

Mr. EDGAR. Thank you very much.

How many SCI centers are there presently?

Mr. DEGEORGE. Nineteen, sir.

Mr. EDGAR. Nineteen centers. And their locations regionally?

Mr. DEGEORGE. Mainly, east of the Mississippi. There are, I believe, four spinal cord injury centers west of the Mississippi.

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[1]The prepared statement of Mr. Frank DeGeorge appears on p. 126.

Mr. EDGAR. So most of them are east.

Mr. DEGEORGE. They are indicated in our full statement.

Mr. EDGAR. Do you know if there are any SCI centers that have any State support at all?

Mr. DEGEORGE. I do not have a direct answer to that question, but I don't believe so. But at the same time, I could submit that in a letter to you.

Mr. EDGAR. The only reason I ask that question, it comes to mind for example that the State of Texas has a great need for SCI centers at this time; they also have great resources at this time. It is estimated that the State of Texas will have some $35 billion of surplus in their budget in the next 10 years due to severance taxes that they are taking on things like fossil fuel oil and natural gas that, by accident, happen to be under their territory. But I would believe they are national resources as well. It would seem to me that in times of $200 billion deficits, it might make some sense to say, "We will come up with $1 million if you will come up with $1 million and pursue establishing one of these centers on a faster track than what might be established if we wait for a 5-year plan or a 10-year plan or a 20-year plan that the VA has." I would just invite you as an organization maybe to have some discussions State-by-State to see whether or not there are possibilities for a State-Federal grant program for the construction of SCI centers.

I recognize that traditionally in the past we have not had that relationship but it may be that some States have surpluses in their budgets and also great needs, and other States may not have surpluses in their budgets and have similar needs, and perhaps a cooperative Federal-State relationship could be developed to provide the funding at least for the construction of the facility.

Mr. DEGEORGE. Congressman, I want to thank you for that lead, but for the record I want to make sure that you and I are not committed to a position of jeopardy, but that we are both still concerned about this country being concerned about our veterans. I am sure that's where you are coming from.

Mr. EDGAR. I am very much concerned that veterans' concerns be national concerns, and we all as a Nation have to respond to them. I am simply saying that at a time when you have limited Federal dollars to spend, we are investing large sums of money in building military bases in Texas.

Mr. DEGEORGE. Yes, sir. I just wanted to make sure that nobody read anything into the——

Mr. EDGAR. Yes, I understand. But I think if we can find $250 billion a year to spend on defense, we might be able to come up with a little funds for responding to those who have served our country well, and I just think that occasionally we need to ask question of whether or not some local participation, even if it was 10 percent or 15 percent would be worthwhile.

Mr. DEGEORGE. Well, I think it's a good recommendation and I definitely will bring it back to my superiors for followup, sir.

Mr. EDGAR. One of the other things that strikes me on page 24 of your testimony, the number of persons responding to your questionnaire who are age 50 and over, is significant. Sixty-four percent of those who are respondents. The 97,000 questionnaires that were sent out and the percentage of returns would lead one to believe

that the demographics show a high proportion of persons who are in need of services being 50 years of age and older, which doubly underscores the need mentioned in your statement of the need for specialized concern for the aging veterans.

Do you see that separate from the geriatric centers that are being established within the VA, or should the VA also be sensitive to making a part of their geriatric research reflect the needs of paralyzed veterans?

Mr. DEGEORGE. We have a very distinct concern that when spinal-cord-injured veterans, regardless of what age, are placed into nursing homes, et cetera, where the age differences and the concerns are different, healthwise as well as agewise, that it does become a serious concern for our membership. At the same time, while we are talking about members over the age of 50, we are getting into the area of geriatrics, older age veterans, we still have the basic concern of the spinal cord injury and the treatment of that person with that injury, and that becomes a very serious problem in nursing homes. Most nursing homes do not understand spinal cord injury and the complications involved.

Mr. EDGAR. So part of the effort is to try to improve the services within the VA throughout its system to try and understand the needs of spinal cord injury?

Mr. DEGEORGE. Yes, sir, we feel that, again, that asking for long-term care beds within the VA system makes appropriate common sense in the treatment of those veterans. Whereas, there is also a relationship between the long-term veteran and the acute spinal-cord-injured veteran being able to communicate on a personal basis when the opportunity arises, to assist overcoming of the basic disability itself.

Mr. EDGAR. What does a spinal-cord-injury patient do who lives in Fargo, N. Dak?

Mr. DEGEORGE. Most generally speaking, watch the snow fall. I would imagine. Being involved in a hockey team as a coach or a manager wouldn't hurt, but as far as I know, we do have several members who live in Sioux Falls in that area and yes, we do have some in Fargo. Some of them are prominent businessmen in the local community and when they need care they usually go to, when they need spinal-cord-injury care, they go to Woods VA Hospital or Hines, Ill., and basically those are the two hospitals that they go into for checkups.

But many of the people who live there have a good experience in life and many of them are professionals in their own sense of the word.

Mr. EDGAR. Thank you very much for your testimony today and we appreciate the thoroughness of your testimony.

Mr. DEGEORGE. Thank you very much for your effort.

Mr. EDGAR. Thank you.

Our final witness will be Mr. Donald Schwab, Director, National Legislative Service of the Veterans of Foreign Wars, accompanied by Fred Juarbe.

Mr. EDGAR. You can proceed with your testimony. Your full statement will be made a part of the record.

STATEMENT OF DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS, ACCOMPANIED BY FRED JUARBE, DIRECTOR, NATIONAL VETERANS SERVICE, VETERANS OF FOREIGN WARS

Mr. SCHWAB. Thank you, Mr. Chairman, and I will summarize. The gentleman on my right and your left is Mr. Fred Juarbe, who is the director of our National Veterans Service.

Mr. Chairman, as you know, the Veterans of Foreign Wars has had a vested interest in the VA hospital and medical care system and construction program for many, many years. Our constituency also has a parochial interest in all 57 projects in the 5-year construction plan.

We are not unhappy with the priorities in the hospital. We are very happy about their going ahead with the Minneapolis hospital and the extensive renovation in Biloxi. The only question we really have with the fiscal year construction for 1984 is that the Baltimore hospital was not included.

The VA has spent $8 million to date on the Baltimore hospital. The design loans are ready. The property has been purchased and they could go immediately ahead with construction of that hospital which is badly needed both for the veterans and for employment purposes.

Other than that, as Mr. Alvarez pointed out, 53 percent of the VA hospitals are over 30 years of age. Mr. Juarbe has on his staff field representatives whose primary function is to survey VA health care facilities, and I am sure they could come up with 10 more hospitals very much in need of replacement.

Incidentally, these surveys are sent routinely to the hospital director concerned, to the chief medical director of the VA, to the chairman and ranking minority members of both Veterans' Affairs Committees and to the Senators and Representatives in whose district, State, these hospitals are located.

The same applies to the building of outpatient facilities. We certainly can't fault the Veterans' Administration on their site selection in these areas. We are quite concerned about the reduction in domiciliary care and the amount of funding for domiciliary care, in the amount of FTEE's to be lost, in view of the fact that they will be cut back to a daily census of 6,700 patients and the MEDIPP program indicates that there is going to be a need for at least 7,900 domiciliary beds.

A question has come up this morning with respect to acute-care beds versus long-term care beds. Public Law 97-72 gave the Administrator or mandates the Administrator to maintain not less 90,000 hospital and nursing care beds combined, and he still has the mandate to maintain 13,000 nursing care beds, but the 90,000 figure is a minimum and this gives him flexibility based on aging veteran population, younger veterans coming along needing different kinds of care.

With respect to the geriatric centers, you have brought out, Mr. Chairman, that Public Law 96-330 authorized seven additional GRECC's and only in this fiscal year budget has the VA got permission and funding to build one more. But in deference to Administrator Walters, we were told at the briefing that he had, in fact,

requested funding for several additional GRECC's but he was only funded for one.

This concludes my summary, Mr. Chairman. I will be happy to respond to any questions. Mr. Juarbe has got a very extensive knowledge of the hospital system and construction programs and I am sure he could respond to any questions you may have also.[1]

Mr. EDGAR. Thank you very much.

Mr. Juarbe, the only question that I would have of you is the question that I asked of the VA dealing with some foresight in terms of 5 years, 10 years, 17 years down the line when we reach the year 2,000. At present rates of construction of these aging facilities, what is the analysis in terms of whether or not, we will have met the needs for replacement and we have a health care facility in place that is a quality health care system?

I am not specifically asking you for the record today, but it might be helpful for you as you request from your service officers and other contacts through the system to do some analysis, given the pressures that we all see with budget deficits and elimination of hospitals, the dragging of those hospital projects on into future fiscal years, whether or not we will really be prepared by the year 2,000 to say:

> We have met the infrastructure needs of old VA hospitals. Will we have adequately cared for the demographic changes, both in terms of aging veterans and the Vietnam era veterans that are coming along which will be a larger and larger portion of the veterans population?

We hear from other colleagues as to the migration of veterans from one part of the country to the other. Part of the concern, I think is that we develop a veterans health care system that is adequate, that we don't overbuild in certain areas where the demographics are going to change again at some point, and yet, we are sensitive to where the veterans needs really are overall.

So if you could do some foresighting with us, it would be helpful.

Mr. JUARBE. May I comment on that?

Mr. EDGAR. Yes.

Mr. JUARBE. We have addressed that question from one standpoint. In every field survey that we conduct, our field representatives are taking into account what the needs of that particular hospital are for the future. Since the inception of the MEDIPP process they have taken into account what proposals are being developed locally regarding MEDIPP and how we feel it would impact the particular mission of that hospital and whether we are in agreement with the VA overall district view or whether our concerns are more for the specific needs of the veterans in that particular area and the availability of that particular care in that specific area.

We continue to assess this through our surveys. If I understand your question correctly, what the demographic needs are, and what the impact is going to be and what the assessment by the year 2,000 of what type of a VA medical system should we have, facilities and so on.

Well, we have addressed that from the standpoint of the snowbirds. We are concerned that there are a number of veterans that

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[1] The prepared statement of Mr. Donald H. Schwab appears on p. 168.

are not being adequately cared for in areas in the Sun belt where there is a tremendous population influx, especially of veterans.

But we have a deep and abiding concern that those facilities or the mission of care for veterans in the founding States, if you will, up in the Northeast and in the North Central States will continue there. Not every veteran will be in a position to move to the Sun belt. Most veterans that utilize the VA medical system are aged veterans. They are veterans whose incomes are at or below the poverty level who have little or no health insurance. Certainly, if that is the case, the case would also be that they would not be likely to move to the Sun belt area. They will be stuck exactly where they are at. And, of course, the younger veterans, the Vietnam veterans that will be in the Northern States, in the snow belt, they will be there because of their careers, of their jobs, of their roots in that area.

So while there is the definite need for considering the demographics into the Sun belt for the development of facilities, there is a continued need up in the Northern States.

Mr. EDGAR. I think your point is well taken. As you know, I chaired for the last 4 years the Northeast-Midwest Congressional Coalition and our concern was not that we terminate new construction in the South and West but that we recognize that we are a nation of regions that have differing needs. We can hear from those colleagues who have concern for migration areas, how can we handle this influx of veterans, how can we handle the development necessary? And one of the questions that I was going to ask the VA was this: Will we have enough water in Florida to handle the veterans facility, because if you look at the demographics of population, they are going to have an influx of people but maybe the natural resources will not be adequate to respond.

Well, at the same time we are caring about those new construction projects, and politicians love to cut the ribbon on new things. We have to also care about the rehabilitation, reconstruction, and replacement of aging facilities. I serve on the Public Works Committee and we did an analysis a few years ago of the New York City public transit system, the subway system. At present rates of funding, we can only bring the New York City subway system up to accessibility standards for the elderly, and handicapped, and modern standards, in 300 years. That is the present rate of how much funds we are committing at the Federal level, and to some degree, at the State and local level, to repair a very large system.

One-third of all of the public transit passengers in the Nation happen to ride on the New York City subway system, that is every day. So we can get excited about building a new system in Atlanta and Miami because there is a need for public transit, but if we neglect the rehabilitation needs of what we have in place, we are going to see further decline and further deterioration.

I am wondering as we move along this system, whether or not there is a point in time when the needs for veterans will outstrip the quality of care given in the veterans hospital system because we neglected to replace, and rehabilitate, and reconstruct, and put adequate facilities in place to meet those needs, and we add then, if that happens, to the enthusiasm of people who don't understand the need for a veterans quality health care system to counter those

in the chorus that say: "We ought to dismantle the system or we ought to fold it into a public health system of some kind or it ought to work under Health and Human Services or whatever fear that the veterans organizations and others have expressed over the many, many years."

So I think you make the right point:

Let's care about, in migration areas, let's care about the demography of aging veterans, but let's not neglect those who stay behind in making sure that their facilities are as modern and as up-to-date, both in terms of acute and long-term care in meeting the needs that they have.

Mr. JUARBE. May I comment on that, Mr. Chairman?

To answer your question more directly, I would say that it is my humble opinion that at the present rate of construction and based on the present plans of the VA, they would not have an adequate facility system by the year 2000, and certainly that would lend itself to what you state. There could be a chorus of individuals who would say that the system is adequate, it is poorly run, it does not meet all the needs and, therefore, veterans should be mainstreamed into a public health system or whatever.

I would like to expand on a couple of other points which my colleague touched on. This committee has a national concern for medical care of all veterans and its individual members have a concern for the members in their area or the VFW has a national concern for all veterans and certainly we all have our own local interests.

The 57 projects that were revalidated and of those 57 projects, I can assure you that we have local VFW constituencies that strongly feel that each one of those projects should be continued. Now we recognize that that is not fiscally feasible as it stands right now for the year 1984. Now as far as the 5-year construction program, that's $5½ billion worth of projects. Each one of those projects our local constituency is in great support of. They are constantly telling us that those projects are needed.

But those projects are not feasible for those 5 years. Otherwise you would probably have an over $1 billion construction project for each one of those years.

As I understand the 5-year construction plan, it's a needs assessment and, of course, they would have to be prioritized. Now going back for a moment to the 57 projects, we were strongly opposed to the revalidation concept because of its implications and innuendos of a poorly managed VA hospital system and all that. Now, in a way, we are glad in the VFW that that process took place because it has given the Department of Medicine and Surgery and the Office of Construction a stronger base. It has shown that they did have a sound and a sensible criterion for establishing future construction projects. There was some fine tuning that was required. That fine tuning has been done.

I would say, with regard to the 57 projects, Mr. Chairman, that if Congress in its wisdom finds a way to mandate each one of those projects, we would be strongly in support of that. We would definitely be concerned that the funding for that would not come out of other VA programs.

Mr. EDGAR. Maybe we could put one MX missile silo next to each project and use a little extra money to complete it.

I really appreciate your statement. We will ask that the VFW give us a hand as we go across the country to the six regions of the country for extensive hearings and anything you can do to help us as we move into the different areas of the country from San Francisco, to Florida, to Milwaukee and to all of the areas that we have selected, we hope to bring members of this committee out into the field to see old hospitals, new hospitals, acute-care facilities, clinics, readjustment counseling centers and all the varied aspects of the health care system and in a hands on kind of experience learn what the system is about. So we will need your help with that.

Thank you for your testimony.

Mr. SCHWAB. Thank you.

Mr. EDGAR. Two additional statements have been submitted for the record by the National Council of Health Centers [1] and by Mr. John F. Sommer, Jr., deputy director, National Veterans Affairs and Rehabilitation Commission, the American Legion.[2] Without objection, both of those statements will be entered into the record.

Mr. EDGAR. The subcommittee stands adjourned.

[Whereupon, at 12:01 p.m., on Wednesday, March 16, 1983, the subcommittee was adjourned.]

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[1] Statement of the National Council of Health Centers appears on p. 179.
[2] Statement of Mr. John F. Sommer, Jr., appears on p. 184.

APPENDIX

STATEMENT OF HON. THOMAS J. DOWNEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I appreciate the opportunity to testify today on behalf of the need for construction of a 120-bed long term care facility at Northport Veterans Administration Medical Center. This construction project has been included in the Administration's 1984 budget request.

Nursing home care is an increasingly important part of the services provided by the Veterans Administration because our country's veterans are growing older. The enormous number of World War II and Korean War veterans are rapidly aging, and transforming the nature of the veteran population. By 1990, more than half of all U.S. males over age 65 will be veterans; by 1995, that number will rise to 60 percent. Most of the World War I veterans were aged 65 to 75 between 1960–1970; aged 75–85 between 1970–1980; and the survivors over age 85 will be most numerous between 1980 and 1990. World War II and Korean veterans face similar age concentrations between 1985–1995; 1995–2005; and 2005–2015. A recent Veterans Administration study indicated that by 2010 there may be more than one million veterans over the age of 85 years, compared to 130,000 in 1980.

On Long Island, New York, there is a disproportionately high share of veterans age 65 and over. There are two major reasons for this unusually large number of veterans: (1) Long Island served as a haven for post-World War II veterans; and (2) the migration of elderly citizens to the Sunbelt States has reversed, and the aged population is staying at home while younger generations move South. A study completed last year for New York State by John Steinle and Associates indicated that Long Island's population of aged veterans will reach its peak well before the national peak year of 1995. Even today, fifty percent of all males over age 65 in Nassau County, and more than one-third in Suffolk, are veterans.

Yet despite this unusually high number of aged veterans, the supply of nursing home beds on Long Island is seriously inadequate. The entire Medical District 3 (of which Northport is a part) has only 660 beds, despite Veterans Administration estimates that the region will need more than 992 beds through 1987. Further, Northport Veterans Administration Medical Center has no nursing home beds at all.

In recognition of this problem, the Veterans Administration has requested $8.2 million for construction of a 120-bed facility at Northport Veterans Administration Hospital in 1984. This construction should supply 91 percent of the projected need for nursing home care beds on Long Island through 1987, according to the Veterans Administration.

The Federal Government has a responsibility to care for its aging veterans and to provide services meeting their needs. As demographics change, so must our health care policies. Therefore, I strongly urge the Committee on Veterans Affairs to approve the Administration's $8.2 construction project at Northport VAMC, and make a commitment to the new needs of America's veteran population.

Thank you for your time.

PREPARED STATEMENT OF HON. MARJORIE S. HOLT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, I appreciate the concern of this Subcommittee and the full Veterans Affairs Committee for the health care needs of America's veterans. I thank you for the opportunity to appear before you today to address this subject as it relates to Maryland.

We have an opportunity to provide a new Veterans Administration Hospital in downtown Baltimore to provide acute care and outpatient services in partnership with the great medical center of the University of Maryland.

The project is planned, designed, and ready to go. I am advised that construction could begin tomorrow if the funding were available. Bids on the first phase of construction had already been received in 1981 when Congress rescinded the appropriation for this hospital.

In addition to the many merits of the project itself, there is an important extra consideration I should mention. Congress is very concerned about creating jobs quickly in depressed areas to reduce tragic levels of unemployment, and here is a large-scale construction project that is ready to start immediately in the heart of a depressed old city.

The cost estimate then was $96 million. Dr. John M. Dennis, vice chancellor for health affairs and dean of the University of Maryland School of Medicine, informs me that the architect believes that cost estimate is still valid because of economic conditions that have prevailed in the construction industry within the past couple of years.

I would remind the Committee that the University has invested more than $3 million to accommodate this facility on its campus and to coordinate its operations with those of University Hospital and the Medical School. The University recognizes the high value of the clinical experience that would be available to medical staff and students in the Veterans Hospital.

The University has donated a site of more than one and a half acres for the VA hospital. It has relocated a parking garage on the site to another location. It designed and constructed its new building for connection with the VA hospital by ramps over Baltimore Street. It increased its Medical School enrollment by 20 slots in anticipation of the new veterans' facility.

Currently, veterans receive out-patient care in facilities at the Federal Building in downtown Baltimore, but are sent to the Loch Raven VA Hospital 6 miles away when they need hospitalization, then return to the out-patient facilities downtown for follow-up care.

The Loch Raven VA hospital was originally built in 1952 as a tuberculosis hospital. It would require extensive and costly renovations to bring it up to modern standards for an acute care hospital. It is not suited to that current use.

The new VA hospital for acute and out-patient care on the University campus would enable Loch Raven Hospital to resume the long-term care mission for which it is designed.

Even more importantly, however, acute care and out-patient care for veterans would be consolidated in the new VA hospital, and would be rendered by the same physicians.

University Hospital is a medical center with professionals in all fields of medical care and research. These resources would be available to the veteran patients at the VA hospital.

There would be many shared services, such as CAT scanning, radiation therapy, renal dialysis, cardiac surgery, special laboratory studies, autopsy facilities, incineration of nuclear and non-nuclear materials, and emergency room services. These shared services would bring substantial savings in construction and operating costs.

I should also note that the downtown location is convenient to the entire Baltimore metropolitan area. Public transportation facilities serve the location from all directions.

Mr. Chairman, this project dates back to approval of design funding during the Ford Administration and to planning efforts by the University and the Veterans Administration in earlier years. It is most unfortunate that the project was stopped in 1981 when construction was ready to begin.

The University has made a substantial investment to accommodate the Veterans Hospital on its campus, and we should not disregard that demonstration of good faith in the intentions of the Federal government.

Finally, this project represents an opportunity to provide the best medical care to our veterans, and I know you share that objective with me.

PREPARED STATEMENT OF HON. JACK HIGHTOWER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, I am pleased to have this opportunity to appear before the Subcommittee to discuss the Amarillo Veterans Hospital Construction project.

I am concerned, as are my constituents and some of my colleagues, about the Administration's planned deferral of funding for the Amarillo facility for at least the next fiscal year, and possibly even longer. I maintain that this deferral is unjustifiable, and that if it is allowed to continue it will work an undue hardship on a facility

that has already had to struggle for many years to adquately care for its veteran patients.

There is no doubt about the need for expansion of the Amarillo Veterans Hospital facility. In hearings before this subcommittee last year, the Amarillo expansion project was scheduled for inclusion in the 1984 budget by the Veterans Administration because of the urgent need for the psychiatric services the completed project will provide. In a report by a project review committee to the Veterans Administration's Facility Planning & Construction Committee, the Amarillo VA Medical Center was said to need expansion because "services have been fragmented and existing spaces are too small to allow for efficient patient care." In a 1981 report, the VA's own Facility Planning & Construction Committee recommended "that the need for a clinical project to correct existing functional, space and privacy deficiencies be considered a serious need at the VAMC Amarillo . . . . Major deficiencies exist even to meet existing workloads." The Amarillo VA Medical Center was constructured in 1939—44 years ago—and since that time no major renovation has taken place at the facility. Surely all this leads to the inevitable conclusion that this facility needs and deserves funding for its expansion.

There is little doubt about the need for redesign of the preliminary plans of the expansion project. The original plans, beginning in about 1975, were made with the concurrence and guidance of the VA Central Office, and as of last year were proceeding to the final construction plan phase. Because of a decision by the Veterans Administration Central Office all construction plans scheduled for funding in the 1984 budget were revalidated. When this revalidation was conducted at the VA Medical Center in Amarillo, it was decided that the preliminary design for the facility was faulty and needed some structural changes. Even though this was a disappointing set-back, the Amarillo VA Medical Facility—already termed by the Central Office to be seriously deficient with its existing facilities to meet current patient needs—agreed to the changes made by the Central Office and accepted the new conceptual plans.

At this point, Mr. Chairman, the agreement on the plans for the Amarillo VA Facility seems to end. The Medical Center itself, as well as some of the VA's Office of Construction staff, agree that the most cost-effective and efficient manner of proceeding is to use the architect who was responsible for the original plans. The VA's General Counsel's Office, however, has not firmly endorsed the use of the same architect for the newly revised plans, instead now maintaining that proceeding with the original architect may only be supported if the record would show that the VA would achieve a substantial cost saving by doing so. I believe that this misplaces the burden of proof. They should continue with the same architect unless some good reason not to do so is demonstrated.

If the VA at this late date chooses to begin again, to search for a new architect, the planned construction of the Medical Center in Amarillo could be delayed indefinitely and its costs escalated. Use of the same architect for the new expansion has several advantages, not only for the veterans in the Western Region and the U.S. Treasury. First, there would be no "lead time" on the project; the current architect already knows the plans for the facility, and has invested a considerable amount of time (and taxpayer money) in working with those plans and the people trying to implement them. Second, the design changes put forward by the VA are minimal enough that they can easily be incorporated into the current design plan. Most of the current architect's plans would be kept in the new designs. Finally, it is surely more cost-effective to continue with a plan that is already underway, rather than interrupt an entire process that is nearly complete only to begin again at square one.

Mr. Chairman, the VA Medical Center at Amarillo began its plans for expansion in 1975. For over 8 years now they have waited to expand the existing medical facility, an expansion which everyone, including the Veterans Administration, acknowledges is long overdue and seriously needed. It may be too late to include funding for the VA Medical Center at Amarillo in the 1984 budget, where it was intended to be both by the Veterans Administration and by this subcommittee. But surely it is not too late to prevent the funding from being rescheduled until an even later time. The Veterans Administration has a choice. By deciding to continue with the same architect, the VA can ensure that the plans will be ready and construction can begin with funds at the earliest possible date. By deciding otherwise, the VA will condemn the Medical Center in Amarillo, Texas, to more years of operating with the "serious deficiencies" that the VA itself has pointed out.

STATEMENT

BY

EVERETT ALVAREZ, JR.

DEPUTY ADMINISTRATOR OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ON

MARCH 16, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU THIS MORNING TO DISCUSS THE VA'S MEDICAL FACILITY CONSTRUCTION PROGRAM, OUR REQUEST FOR AUTHORIZATION OF THESE CONSTRUCTION PROJECTS BY THE COMMITTEE ON VETERANS' AFFAIRS, AND OUR FIVE YEAR MEDICAL FACILITY CONSTRUCTION PLAN WHICH WAS SUBMITTED TO THE COMMITTEE IN JUNE 1982 AND COVERS THE PERIOD OF FISCAL YEARS 1983 THROUGH 1987.

THE VETERANS ADMINISTRATION HOSPITAL SYSTEM INCLUDES 172 MEDICAL CENTERS LOCATED THROUGHOUT THE UNITED STATES WHICH PROVIDE A COMPREHENSIVE RANGE OF HEALTH SERVICES TO OUR NATION'S VETERANS. THE SYSTEM OPERATES IN OVER 5000 SEPARATE BUILDINGS WITH OVER 100 MILLION SQUARE FEET OF SPACE. LIKE THE VETERAN POPULATION WE SERVE THIS VA PHYSICAL PLANT IS AGING. IN 1930 THE NEWLY FORMED VETERANS ADMINISTRATION INHERITED NUMEROUS MEDICAL FACILITIES FROM OTHER AGENCIES. ADDITIONAL VA MEDICAL FACILITIES WERE ACQUIRED FROM THE MILITARY OR WERE CONSTRUCTED IMMEDIATELY AFTER WORLD WAR II AND IN THE FOLLOWING YEARS. MOST VA FACILITIES NOW HAVE BUILDINGS OVER 30 YEARS OLD. INDEED, 53 PERCENT OF VA HOSPITAL BEDS ARE HOUSED IN BUILDINGS WHICH ARE OVER 30 YEARS OF AGE. THE MAJORITY OF VA MEDICAL CENTERS ALSO WERE CONSTRUCTED WITHOUT SIGNIFICANT OUTPATIENT CAPABILITY, AND SUBSTANTIAL CHANGES IN FIRE SAFETY CODES AND RELATED REQUIREMENTS HAVE BEEN MADE SINCE THE ORIGINAL CONSTRUCTION. WHILE MUCH IMPROVEMENT HAS BEEN ACCOMPLISHED, A GREAT DEAL REMAINS TO BE DONE.

THE DELIVERY OF QUALITY MEDICAL CARE DEMANDS A COMMITMENT TO A CAPITAL INVESTMENT PROGRAM WHICH PRESERVES AND PROTECTS FACILITIES AND PROVIDES IMPROVEMENTS TO KEEP PACE WITH STATE OF THE ART MODERN MEDICAL CARE. PROGRAM ENHANCEMENTS, RAPIDLY ADVANCING TECHNOLOGY, THE DEMANDS OF MODERN HEALTH CARE, CODE CHANGES, STANDARDS OF THE JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS, AND THE NEED TO ELIMINATE ARCHITECTURAL BARRIERS ALL CONTRIBUTE TO THE NEED TO MAKE IMPROVEMENTS. AS YOU KNOW, OUR PROPOSED FISCAL YEAR 1984 CONSTRUCTION BUDGET NOW BEFORE THE CONGRESS IS THE LARGEST CONSTRUCTION BUDGET EVER PROPOSED BY THE VETERANS ADMINISTRATION. THIS PROPOSAL REFLECTS OUR CONTINUED STRONG COMMITMENT TO MEETING THE FACILITY NEEDS OF A MODERN, COMPREHENSIVE AND INDEPENDENT HEALTH CARE DELIVERY SYSTEM WHICH PROVIDES FOR THE HEALTH CARE NEEDS OF OUR NATION'S VETERANS.

OUR MAJOR PROGRAM LEVEL REQUEST OF 753 MILLION DOLLARS INCLUDES FUNDING FOR 35 PROJECTS INCLUDING THE REPLACEMENT HOSPITAL IN MINNEAPOLIS, MINNESOTA; SEVEN NURSING HOME CARE UNITS WHICH WILL PROVIDE 840 NEW

NURSING HOME CARE BEDS; AND OTHER IMPROVEMENTS IN CLINICAL SERVICES, PATIENT ENVIRONMENT, CORRECTION OF FIRE SAFETY AND ELECTRICAL DEFICIENCIES, AND IMPROVEMENTS IN MEDICAL CENTER SUPPORT AREAS.

IN ACCORDANCE WITH THE PROVISIONS OF TITLE 38, SECTIONS 5004 AND 5007, THE VETERANS ADMINISTRATION IS REQUESTING THE AUTHORIZATION OF MAJOR CONSTRUCTION PROJECTS AS DETAILED IN VOLUME 6 OF OUR BUDGET SUBMISSION. OF THE 35 PROJECTS FOR WHICH FUNDING IS REQUESTED IN FISCAL YEAR 1984, 29 REQUIRE THE AUTHORIZATION OF THIS COMMITTEE THESE 29 PROJECTS HAVE AN ESTIMATED TOTAL COST OF $299.1 MILLION. THE REMAINING PROJECTS HAVE BEEN PREVIOUSLY AUTHORIZED BY THE COMMITTEE. IN ADDITION, WE ARE REQUESTING YOUR AUTHORIZATION TO PROCEED WITH WORKING DRAWINGS IN FY 1984 USING VA STAFF FOR FIVE MAJOR CONSTRUCTION PROJECTS WHICH ARE CURRENTLY PLANNED FOR FISCAL YEAR 1985. FURTHER, WE REQUEST LEASE AUTHORIZATION FOR THE RELOCATION AND EXPANSION OF THE VA OUTPATIENT CLINIC IN PORTLAND, OREGON.

CONSTRUCTION PROJECTS TO MAKE IMPROVEMENTS IN VA MEDICAL FACILITIES ARE IDENTIFIED THROUGH THE PLANNING PROCESS. THE FIVE YEAR MEDICAL FACILITY CONSTRUCTION PLAN SUBMITTED IN JUNE 1982, REPRESENTS THE FOURTH ANNUAL UPDATE TO THE CONGRESS ON PLANS FOR MAJOR CONSTRUCTION AT VA MEDICAL CENTERS. THE PLAN COVERS THE PERIOD FROM FISCAL YEAR 1983 THROUGH 1987 AND IDENTIFIES 252 PROJECTS HAVING A CURRENT ESTIMATED COST APPROACHING 5 1/2 BILLION DOLLARS. THE PROJECTS IDENTIFIED IN THE PLAN WILL PROVIDE NEEDED IMPROVEMENTS AT VA MEDICAL CENTERS TO KEEP PACE WITH THE MANY CHANGES IN TECHNOLOGY, LEVELS AND TYPES OF SERVICE, AND HEALTH CARE DELIVERY METHODS.

THIS PLAN IS A PRODUCT OF THE DEPARTMENT OF MEDICINE AND SURGERY'S FACILITY PLANNING PROCESS THROUGH WHICH EACH MEDICAL CENTER UPDATES THEIR FACILITY PLAN ON AN ANNUAL BASIS. THESE PLANS ARE REVIEWED AND ADJUSTED AS NECESSARY TO FORM A COHESIVE NATIONAL STRATEGY CONSISTENT WITH ANTICIPATED BUDGETARY LEVELS. THE MEDICAL CENTERS' FIVE YEAR FACILITY PLAN DETAILS CONSTRUCTION STRATEGIES AND SPECIFIC PROJECTS NEEDED TO SUPPORT PROGRAM MISSION AND LEVELS

OF SERVICE AT EACH SPECIFIC MEDICAL CENTER. THE IMPLEMENTATION OF THE MEDICAL DISTRICT INITIATED PROGAM PLANNING PROCESS (MEDIPP) WILL STRENGTHEN THESE FACILITY PLANS BY PROVIDING FIRM PROGRAMMATIC PLANS FOR THE DELIVERY OF SERVICE AND THUS A STRONGER FOUNDATION UPON WHICH TO UNDERTAKE SPECIFIC FACILITY PLANNING.

IN ACCORDANCE WITH SECTION 5007, THE FIVE YEAR MEDICAL FACILITY CONSTRUCTION PLAN ALSO INCLUDES A LISTING OF THE TEN MEDICAL CENTERS WHICH WE CONSIDER MOST IN NEED OF CONSTRUCTION, REPLACEMENT, OR MAJOR MODERNIZATION. IN THE JUNE 1982 PLAN, WE HAVE ADDED THE BALTIMORE METROPOLITAN AREA TO THE LIST. WE ARE ASSESSING THE NEEDS OF THE BALTIMORE FACILITIES AND WE WOULD EXPECT TO RECOMMEND A CONSTRUCTION STRATEGY IN THE NEAR FUTURE. THE MEDICAL CENTER WHICH APPEARED ON THE PREVIOUS LIST OF TEN AND IS NOT ON THIS YEARS LIST IS PALO ALTO, CALIFORNIA (MENLO PARK DIVISION). THE NEEDS OF THIS FACILITY ARE BEING MET THROUGH MAJOR CONSTRUCTION FUNDED IN FY 1982. MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, WE BELIEVE THAT THIS PLAN OFFERS A RESPONSIBLE APPROACH TO MEETING THE FACILITY NEEDS OF THE VA HEALTH CARE SYSTEM. IT

REPRESENTS WHAT WE BELIEVE TO BE REQUIRED TO KEEP THE VA INFRASTRUCTURE IN AN ACCEPTABLE CONDITION. WE RECOGNIZE, HOWEVER, THAT AVAILABLE RESOURCE LEVELS MAY NECESSITATE CHANGES IN THIS PLAN AS WE MOVE TOWARD ITS IMPLEMENTATION.

I WOULD BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

"BED CAPACITY IMPACT OF IMPROVEMENTS TO PATIENT ENVIRONMENT"
VA HOSPITALS

	Estimated Future Bed Losses			Beds Lost 1/1978 - 6/1982		
VAMC	Patient Privacy	Fire and Safety	TOTAL	Patient Privacy	Fire and Safety	TOTAL
Albany	7	-	7	2	-	2
Albuquerque	-	-	-	26	12	38
Alexandria	23	-	23	-	8	8
Allen Park	18	-	18	70	-	70
Altoona	-	-	-	8	-	8
Amarillo	-	-	-	8	-	8
American Lake	25	-	25	118	-	118
Ann Arbor	31	-	31	12	-	12
Asheville	65	-	65	1	-	1
Atlanta	-	-	-	-	-	-
Augusta	81	11	92	29	32	61
Baltimore	100	-	100	-	-	-
Batavia	11	-	11	2	-	2
Bath	-	-	-	-	-	-
Battle Creek	-	23	23	159	72	231
Bay Pines	-	-	-	-	-	-
Beckley	-	-	-	-	-	-
Bedford	47	-	47	53	-	53
Big Spring	-	-	-	-	-	-
Biloxi	230	-	230	15	-	15
Birmingham	20	50	70	-	-	-
Boise	-	-	-	6	4	10
Bonham	-	-	-	-	-	-
Boston	62	-	62	14	18	32
Brockton	52	26	78	2	-	2
Bronx	-	-	-	-	-	-
Brooklyn	10	-	10	-	-	-
Buffalo	61	-	61	40	-	40
Butler	-	-	-	-	-	-
Canandaigua	5	-	5	77	16	93
Castle Point	-	-	-	2	-	2
Charleston	6	-	6	4	-	4
Cheyenne	3	2	5	-	-	-
Chicago (L.S.)	47	-	47	4	-	4
Chicago (W.S.)	-	-	-	-	-	-
Chillicothe	62	9	71	36	25	61
Cincinnati	28	20	48	-	-	-
Clarksburg	4	-	4	8	-	8
Cleveland	52	56	108	45	-	45

"BED CAPACITY IMPACT OF IMPROVEMENTS TO PATIENT ENVIRONMENT"
VA HOSPITALS

VAMC	Estimated Future Bed Losses			Beds Lost 1/1978 - 6/1982		
	Patient Privacy	Fire and Safety	TOTAL	Patient Privacy	Fire and Safety	TOTAL
Coatesville	134	-	134	168	-	168
Columbia	10	-	10	-	-	-
Columbia	-	-	-	-	-	-
Dallas	42	-	42	-	-	-
Danville	-	-	-	34	160	194
Dayton	133	44	177	54	-	54
Denver	24	-	24	14	-	14
Des Moines	37	19	56	6	-	6
Dublin	72	-	72	-	-	-
Durham	3	-	3	20	-	20
East Orange	1	-	1	-	-	-
Erie	-	-	-	4	-	4
Fargo	-	-	-	-	-	-
Fayetteville, AR.	5	-	5	12	-	12
Fayetteville, NC.	-	-	-	6	-	6
Ft. Harrison	15	-	15	5	-	5
Ft. Howard	48	56	104	5	-	5
Ft. Lyon	80	-	80	135	-	135
Ft. Meade	-	-	-	-	-	-
Ft. Wayne	-	-	-	-	2	2
Fresno	40	-	40	-	-	-
Gainesville	69	-	69	-	-	-
Grand Island	-	-	-	5	-	5
Grand Junction	-	-	-	-	-	-
Hampton	-	-	-	-	-	-
Hines	171	-	171	18	-	18
Hot Springs	33	-	33	-	-	-
Houston	53	-	53	152	22	174
Huntington	-	-	-	-	-	-
Indianapolis	3	-	3	168	26	194
Iowa City	-	-	-	26	7	33
Iron Mountain	6	-	6	24	-	24
Jackson	-	-	-	22	23	45
Kansas City	-	10	10	42	-	42
Kerrville	41	-	41	11	-	11
Knoxville	-	-	-	93	-	93
Lake City	10	-	10	40	-	40
Leavenworth	15	-	15	-	-	-
Lebanon	67	-	67	21	-	21

"BED CAPACITY IMPACT OF IMPROVEMENTS TO PATIENT ENVIRONMENT"
VA HOSPITALS

VAMC	Estimated Future Bed Losses			Beds Lost 1/1978 - 6/1982		
	Patient Privacy	Fire and Safety	TOTAL	Patient Privacy	Fire and Safety	TOTAL
Lexington	60	-	60	54	-	54
Lincoln	-	-	-	27	-	27
Little Rock	-	-	-	49	-	49
Livermore	-	-	-	-	-	-
Long Beach	-	3	3	93	37	130
Loma Linda	-	-	-	-	-	-
Los Ang. Brent.	-	-	-	-	-	-
Los Ang. Wads.	-	-	-	-	-	-
Louisville	61	-	61	-	-	-
Lyons	-	201	201	49	-	49
Madison	-	-	-	-	-	-
Manchester	-	-	-	-	-	-
Marion, IL.	-	-	-	-	4	4
Marion, IN.	-	-	-	169	-	169
Marlin	24	-	24	1	-	1
Martinez	42	-	42	4	4	8
Martinsburg	-	-	-	-	-	-
Memphis	99	-	99	-	-	-
Miami	-	-	-	-	-	-
Miles City	-	-	-	-	-	-
Minneapolis	69	38	107	60	-	60
Montgomery	-	-	-	3	3	6
Montrose	52	-	52	24	-	24
Mountain Home	-	-	-	-	-	-
Murfreesboro	45	-	45	130	-	130
Muskogee	36	2	38	-	2	2
Nashville	107	-	107	-	-	-
New Orleans	67	-	67	31	14	45
New York	67	-	67	-	-	-
Newington	-	-	-	-	-	-
Northampton	10	-	10	64	6	70
North Chicago	306	-	306	121	66	187
Northport	-	-	-	-	-	-
Oklahoma City	65	12	77	-	-	-
Omaha	2	-	2	37	-	37
Palo Alto	28	-	28	-	-	-
Perry Point	170	-	170	176	-	176
Philadelphia	75	-	75	-	-	-
Phoenix	-	-	-	-	-	-
Pittsburgh(HD)	65	-	65	10	-	10
Pittsburgh(UD)	60	40	100	1	-	1
Poplar Bluff	-	-	-	-	-	-
Portland	-	-	-	-	-	-
Prescott	21	26	47	-	-	-

"BED CAPACITY IMPACT OF IMPROVEMENTS TO PATIENT ENVIRONMENT"
VA HOSPITALS

VAMC	Estimated Future Bed Losses			Beds Lost 1/1978 - 6/1982		
	Patient Privacy	Fire and Safety	TOTAL	Patient Privacy	Fire and Safety	TOTAL
Providence	21	-	21	-	-	-
Reno	-	-	-	-	-	-
Richmond	-	-	-	-	-	-
Roseburg	48	-	48	-	-	-
Saginaw	-	-	-	-	-	-
Salem	58	-	58	54	22	76
Salisbury	-	-	-	54	52	106
Salt Lake City	8	-	8	25	-	25
San Antonio	-	-	-	-	-	-
San Diego	-	-	-	-	-	-
San Francisco	-	-	-	-	-	-
San Juan	63	-	63	-	-	-
Seattle	-	-	-	-	-	-
Sepulveda	28	-	28	25	-	25
Sheridan	-	-	-	14	-	14
Shreveport	-	10	10	-	-	-
Sioux Falls	93	-	93	-	-	-
Spokane	15	24	39	-	-	-
St. Cloud	73	22	95	12	-	12
St. Louis	-	-	-	-	-	-
Syracuse	40	-	40	22	-	22
Tampa	-	-	-	-	-	-
Temple	87	5	92	24	18	42
Togus	64	-	64	57	-	57
Tomah	190	-	190	-	-	-
Topeka	19	-	19	36	-	36
Tucson	-	-	-	-	-	-
Tuscaloosa	20	-	20	-	-	-
Tuskegee	-	-	-	212	-	212
Vancouver	-	-	-	-	-	-
Waco	-	-	-	-	-	-
Walla Walla	-	-	-	40	-	40
Washington D.C.	110	-	110	-	-	-
West Haven	-	-	-	-	-	-
West Roxbury	-	-	-	-	-	-
White River Jct.	-	-	-	-	-	-
Wichita	-	-	-	44	-	44
Wilkes-Barre	77	-	77	-	-	-
Wilmington	-	10	10	-	-	-
Wood	24	-	24	26	155	181
TOTAL	4,731	719	5,450	3,574	810	4,384

GRAND TOTAL 9,834

SOURCE: DM&S Circular 10-98-82
Dated June 9, 1982

Office of General Counsel Washington D.C. 20420

Veterans Administration

In Reply Refer To: 02

APR 19 1983

Honorable Bob Edgar
Chairman, Subcommittee on
Hospitals and Health Care
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed are answers to a number of questions you sent to the Veterans Administration concerning the March 16, 1983 hearing on the VA's medical construction program.

I appreciate this opportunity to provide further information.

Sincerely yours,

John P. Murphy

JOHN P. MURPHY
General Counsel

Enclosures

QUESTION 1

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

VA is authorized to provide grants to States for the construction or renovation of existing State-operated medical facilities to furnish nursing care to eligible veterans. State nursing homes' average cost per bed was estimated to be about $48,000 in FY 1982. In contrast, VA's nursing homes were reported to be constructed for about $80,000 per bed in FY 1982. GAO auditors have been looking into some of the reasons for this significant difference. The auditors were told that VA construction standards are more stringent than the States, particularly seismic requirements. Furthermore, VA does not impose several Federal laws and regulations applicable to VA construction on similar State-supported construction such as the Buy American Act; Small Business Act, Section 8(a); and the Federal Procurement Regulations.

(1) Why are States not required to meet VA's stringent seismic requirements for nursing home construction?

(2) Aren't you concerned that State veterans' homes are not as seismically sound as VA facilities?

(3) Are there any other construction standards or requirements that VA imposes on its nursing care facilities that are not imposed on the States that tend to make VA's nursing home construction cost higher than State veterans' homes?

(4) Why doesn't VA impose the Buy American Act; Small Business Act, Section 8(a); and the Federal Procurement Regulations on State-supported construction?

ANSWER:

(1) The VA requirements for State nursing homes, and follow-up review comments, have requested compliance with State codes for seismic resistance. The reasons for not directly using the VA Seismic Code is because all VA centers with "seismic concern" have had specific "site evaluation" studies to furnish a design parameter to use for all projects at each respective site whereas similar studies have not been made at all possible State nursing home sites.

As to cost differential, it is not expected to be of significant cost contrast, particularly in recent years, for one-story or low rise State nursing homes, even in the higher risk zones, as the Uniform Building Code zonal map (used in the critical States) can in some instances be more stringent than the VA code using the locally determined design parameter.

The next revision of the VA Regulations for State Nursing Homes will slightly modify the current statement on seismic design to assure that the design will comply with the latest edition of the Uniform Building Code or the particular State requirements, whichever is greater.

(2) There is no concern that State veterans' homes constructed in compliance with State codes are not seismic resistant.

(3) Standards and requirements for State and VA nursing homes are similar in many respects, but they are not identical. VA nursing homes are designed to be, and operate as, part of a medical center complex, compatible with the total hospital environment. They comply with a uniform national standard, which allows local variations based on local codes or practice, with more emphasis on life cycle cost considerations than on initial construction cost. They are completely protected by automatic sprinkler systems, and must comply with Federal policies (Executive Orders) relating to energy conservation. State facilities comply only with local codes and standards, and only those Federal requirements imposed by law or regulation.

(4) OMB Circular A-102 (Revised) "Uniform Administrative Requirements for Grants-in-Aid to State and Local Government" promulgated the standards to be imposed upon the States as a condition to receiving Federal grants. Attachment "O" to that circular covers procurement standards and states that no additional requirements shall be imposed upon grantees by Executive agencies unless required by Federal law or Executive Orders or authorized by the Administrator for Federal Procurement Policy. Therefore, VA has not imposed the Buy American Act; Small Business Act, Section 8(a); and the Federal Procurement Regulations on State-supported construction.

If any State veterans' home supported by VA funds for the construction or renovation of its existing medical facilities should cease to be a State facility operated principally for veterans with a specified period of time, VA must consider recovering the funds provided under the Federal grant.

(1) Has VA developed regulations to recover Federal funds if State facilities cease operation principally for veterans or change ownership? If not, why?

(2) Have any State facilities assisted by Federal funds ceased operation principally for veterans or changed ownership? If so, how many? How much did VA recover?

ANSWER:

(1) VA has not published regulations to recover Federal funds if State facilities cease operation or change ownership. Recapture provisions are included in the grant agreement.

(2) All State home facilities assisted by Federal funds have continued to be operated for furnishing domiciliary, nursing home or hospital care to veterans; hence, there has been no need to recapture funds.

Question 2:

On September 30, 1982, GAO recommended that you propose nursing home care unit construction to the Congress only after a thorough consideration of less costly alternatives by requiring planners to (1) supplement national projections with local information on actual and projected needs for nursing home care in each medical district; (2) consider meeting nursing home needs wherever possible through greater use of the contract community nursing home program; and (3) consider meeting nursing home needs by renovating, converting, or changing the mission of existing VA facilities.

(1) Have these recommendations been applied to the projects requested for funding in Fiscal Year 1984?

(2) The justifications furnished for each proposed nursing home project mention projected needs calculated at the national level, then broken down by district. Do you have more specific local information on actual demand for nursing home care at the VAMC level? If so, why was it not included as part of the justification in each proposal?

3) Do you know how many vacant community nursing care beds are available in the hospital primary service area at each of the stations which could host a new VANHCU?

ANSWER:

(1) The GAO recommendations, as put forth to Congress, have been, to an extent, incorporated into planning efforts applied to the FY 1984 NHC projects. However, full incorporation of these recommendations will not be possible until our recently initiated MEDIPP process is approved and is able to provide the necessary information to implement the recommendations of GAO Report HRD-2-114, particularly the community/state nursing home issue. The 1982 MEDIPP submissions from each VA medical district specifically examined the actual demand for nursing home care at the VAMC level, determined the numbers of community NHC beds available in the hospital primary service area and projected a district-wide need for NHC beds in the 1985-1990 planning horizon. Essentially, the District MEDIPP submissions validated previous planning strategies to build VA NHC beds prior to 1984, but this information and specific information on 1985 and beyond NHC needs has not yet been approved by the Chief Medical Director and therefore is not yet available for release. Final approval of the MEDIPP plan by the CMD will lead to specific policies on related issues.

(2) Local information on actual demand was collected and analyzed as part of the individual Districts' MEDIPP submissions. As this data has not been formally approved, it is not yet available.

(3) The preparation of the individual District MEDIPP submissions included an analysis of the available community NHC beds in the hospital's primary service area.

QUESTION:

The proposed nursing home care unit at the San Francisco VAMC is estimated to cost $14.7 million--far more than the other 120-bed nursing homes. I understand that environmental opposition and parking constraints are responsible for a large part of this cost.

(1) How much of this projected cost is related to specific site constraints which might be avoided if this project were located elsewhere in the medical district?

(2) What actions have you taken to try to meet site parking requirements through the use of adjacent National Park Service land?

(3) I understand VA's "Revalidation Committee" recommended deferring this project until parking arrangements were made with the Department of the Interior, or that the project be relocated to Livermore or Palo Alto? Why has this project now been requested for funding with the addition of a two-story parking garage?

(4) How much would this project cost if it were relocated to Livermore?

ANSWER:

(1) The cost of the 12-bed NHCU would be $10.5 million ($14.7 million less $4.2 million for the parking structure).

(2) Local negotiation with Golden Gate National Recreation Area (GGNRA) of the National Park Service over the past five years has produced no results. The VA sent a request to the Secretary of Interior to negotiate parking facilities and the request was denied. However, the Department of Interior is reconsidering that decision.

(3) The VA revalidation team explored the situation at VAMC San Francisco pertaining to parking and NHCU siting. Due to the fact that the VAMC San Francisco is located in the population center of the area and has all of desired resource support, the agency decided to place the NHCU at VAMC San Francisco.

The parking structure will replace parking spaces lost to construction of the nursing home.

(4) If this NHCU were to be built at VAMC Livermore, the cost would be $10.5 million.

Question:

DM&S has indicated that the proposed 60-bed NHCU for Providence, Rhode Island, is the lowest priority nursing home in the FY 1984 budget request. I have been told that the VA's revalidation team that visited Providence remained unconvinced of the need for this project.

(1) Can you furnish any additional justification for the timing and location of this project?

(2) What plans do you have to apply a similar revalidation to all future planned construction programs?

Answer:

(1) The revalidation team for the Providence, Rhode Island, NHCU project had reservations as to the need for this project unless a greater demand could be demonstrated. The proposed construction plans themselves were considered to be well organized for the restrained site and recognized special conditions at the medical center.

Further analysis regarding the need for additional NHC beds was amply demonstrated by:

- The 150 person waiting list for placement in the state nursing home;

- A state construction freeze on NHC beds;

- The medical center's in-house census of 23 patients considered to be NHC candidates;

- The projected need for 67 additional NHC beds in the district;

- A district waiting list of 145 NHC candidates.

The final decision of the FPACC Steering Committee was to revalidate the project for inclusion in the FY 1984 budget request.

(2) The Department of Medicine and Surgery evaluation of the revalidation process for the possible FY 1984 projects showed that the planning processes employed by DM&S in the past have been basically sound. Some improvements to the present planning process were identified through the revalidation effort and these improvements will be incorporated into the ongoing DM&S planning process. As such, there is no plan to initiate a subsequent revalidation process, as a separate formalized effort, in the DM&S planning process. Revalidation of projects will be a part of our normal project development and evaluation process.

QUESTION 3:

STATE HOMES

In an October 22, 1981 report, GAO found that the VA had not effectively planned and coordinated the construction and use of VA, State home and contract community nursing homes to meet anticipated demands. GAO reported that VA and State nursing homes may be constructed in some communities that already have too many private nursing home beds, while other medical districts may have a shortage of nursing home beds to meet anticipated demand. VA agreed to coordinate its planning efforts with State and local planning agencies and the National Association of State Veterans Homes.

(1) Have you done this? If so, what effect have these efforts had on your MEDIPP plans and on your construction plans?

(2) How much are you seeking for State home construction projects in FY 1984? Will that be enough to fund all pending construction projects? If not, why aren't you seeking more?

(3) How do you set priorities for State home construction projects?

(4) What role do you project for State facilities in sharing the burden that aging veterans are expected to place on VA's health care system? Are States expected to alleviate the demand for VA's domiciliary beds?

(5) What can VA do to stimulate State-sponsored construction of veterans' homes?

ANSWER:

(1) The GAO study based its conclusion on the VA's application of a 20 percent VA supported share of the veterans' nursing home care needs in the future. This share was to be met by a 40-40-20 program mix for VA, community, and State nursing homes, respectively. Since that time, the Medical District Initiated Program Planning (MEDIPP) process has been implemented, which makes the projected 20 percent share as well as the 40-40-20 ratio obsolete. Current methodology provides for each Medical District to select a VA supported share which best fits its needs. Each District developed its nursing home capability based on guidance of a VA supported share ranging from 12-16 percent, and could select a share outside the established range if the District's assessment quantitatively supported a different share. The methodology considered both VA owned and operated nursing home beds as well as community and State home care availability. Districts had the flexibility to determine the proportion of VA nursing home care beds having been provided guidance of 25-40 percent, and the proportions of community and State home capacity based on their planning targets of demand for services. They were encouraged to involve State and local nursing home care officials in determining the anticipated supply of community and State resources.

(2) $18 million has been requested. This amount will fund 26 percent of the projects (27% of the estimated project costs) submitted as of January 31, 1983.

(3) Priorities for State home construction projects have traditionally been set by awarding grants in the order in which applications were received. Based upon the GAO recommendation, the priority list will be reviewed for any projects that warrant a higher priority to meet VA programmatic needs as identified by MEDIPP. Changes will be made if fully justified. Meantime, to avoid confusion to the States' planning efforts, and to assure continuation of grant awards during the transition, we are continuing to award the grants in the order in which they are received.

(4) The State home facilities are considered as a cost effective adjunct to attaining VA's goal of providing health care to eligible veterans. States are not expected to alleviate the demand for VA's domiciliary beds.

(5) To accelerate State-sponsored construction, the amount appropriated for construction of State extended care facilities could be increased in FY 1984 and maintained in subsequent years. This would shorten the waiting time for funding which is now from four to six years, and allow States to anticipate when Federal funds would be available so that they could seek State funds accordingly. Full utilization of appropriated funds would be assured if funds were allowed to remain available until expended, as the law provides, rather than lapsing in three years as stipulated in recent appropriation language.

ADVANCED PLANNING FUND

Question: In a December 1981 report to this Subcommittee, GAO suggested that VA be allowed to extend the Advanced Planning Fund to cover final design work on construction projects. GAO pointed out that such an action could reduce the time it takes to complete these projects, but that savings would be offset if the Congress did not approve or fund any of the projects. I see that in this year's budget request you are asking for "authorization...to expend appropriated funds to accomplish working drawing design on five high priority projects utilizing Office of Construction in-house resources during FY 1984." (pg. 32-1.)

Is this request consistent with GAO's suggestions?

Answer: To some extent, the request to proceed with working drawings design in five priority projects utilizing in-house resources parallels the GAO suggestion, except that in-house technical staff funded from the General Administration Minor Appropriation will design these projects. Advanced Planning Funds currently are used only for preliminary development work involving outside A/Es. The proposal does achieve a time saving.

Question: Are these in-house resources coming from the Advanced Planning Fund? How much do you expect to spend on working drawings for each project?

Answer: The in-house resources are coming from the General Administration category of the Construction, Minor Appropriation where in-house resources are funded. On the other hand, the GAO proposal would establish a separate fund for design in the Construction, Major Appropriation which would use outside (Architect/Engineer) resources. The in-house expenditures for these projects are as follows:

	FTE	FTE COST ($000)
Alexandria, LA - 120-bed NHCU	3	125
American Lake, WA - New Laundry	3	125
Chillicothe, OH - Renovate Bldg. No. 1 (Phase III)	3.8	166
Shreveport, LA - OPC Building	4.3	187
Shreveport, LA - Upgrade Primary Distribution System & Elevators	1.3	56

Question: What makes these five projects such a high priority? Are they the highest priority projects for which you expect to request

construction funds in FY 1985? Why are you only proposing to fund five projects this way?

Answer: All previous work on these projects has been done in-house and completed for some time. The Department of Medicine and Surgery considered them among their highest priority projects for construction funding consideration in FY 1985 and it seemed prudent not to lose the design momentum. We are only proposing five projects because there is a very limited capacity for performing in-house design work. Other than the time and resulting cost (inflation) savings, it is desirable to perform each year a small portion of working drawing design in-house. The design work provides further learning and development opportunities for our technical staff used in their roles as reviewers, designers, and technical experts for the entire VA in all architectural-engineering matters.

Question: How much time do you expect to save on these projects by funding their working drawings with in-house resources in FY 1984? What do you expect the overall cost savings (or avoidance) to be on each project?

Answer: It is expected to save at least one year which translates to one year's inflation savings.

Question: Have you submitted or do you intend to submit legislation to allow expansion of the Advanced Planning Fund as GAO suggested?

Answer: We have initiated discussions with OMB with respect to inaugurating a design fund for working drawings similar to the Advanced Planning Fund (APF) for preliminary drawings.

Question: How many of the major construction projects in this budget have been funded through the Advanced Planning Fund and are now on hold awaiting Congressional approval and funding? What delay are they experiencing?

Answer: Thirty-five projects were processed through the Advanced Planning Fund and are awaiting Congressional approval. The delay they are now experiencing is the time between completion of preliminary plans and the time Congress appropriates funds for working drawing design. This could be twelve to eighteen months.

ASBESTOS ABATEMENT

Question: You are requesting $4 million for an asbestos abatement program. Your justification mentions that you have a study underway to determine the extent of intensity of asbestos hazards in VA facilities.

(1) What is the status of your study? Have you identified on-going and proposed projects where an asbestos hazard exists?

(2) Why do you need a special line item for asbestos abatement? Aren't the costs built into the individual projects' costs?

Answer: The study is on-going and is being conducted by the Department of Medicine and Surgery. Yes, asbestos hazards have been identified for on-going and proposed projects. Corrective action is underway. As additional asbestos hazard information becomes available, projects will be established using available funding in the asbestos line item.

The presence or extent of an asbestos hazard problem is frequently not known at the time project budget estimates are prepared. At times, the problem is concealed and only comes to light when existing walls, floors, and ceilings are removed during construction. A separate line item enables us to fund necessary corrective action. We also wish to identify larger costs for correction of asbestos hazards through separate funding from the individual project.

QUESTION 6:

MEDIPP

We know that DM&S is placing a great deal of reliance on its Medical District Initiated Program Planning (MEDIPP) process to provide a basis for its future course. By now, each of the 28 districts have submitted their plans--including assessments of veterans' health care needs and what VA must do to be able to meet those needs--and central office officials should have reviewed these plans and formulated policy recommendations to the Chief Medical Director. I understand a briefing of the Administrator is scheduled for Friday (3/18/83).

1. Are you where you expected to be with this initial round of MEDIPP submissions?

2. Have the districts' submissions met your expectations regarding the thoroughness of their analyses and the support for their recommendations?

3.(i) Can you discuss any significant policy changes you plan to make based on these submissions?

3.(ii) For example, will you be changing the missions of any medical centers?

4. What decisions have you made regarding how and when these policy changes will be implemented?

5.(i) How much has this process cost VA?

5.(ii) How much staff time has been invested in it?

5.(iii) What have you spent so far on consultants for this effort?

ANSWER:

1. Considerable progress was made toward accomplishing several MEDIPP objectives. Specifically, the initial MEDIPP plans provide a system-wide profile on veteran need for clinical programs and services to 1990, information on veteran patient utilization, and data on the demographic characteristics of the veteran population. The plans contain projections of hospital, nursing home and domiciliary bed requirements to meet estimates of demand. Plans successfully assessed the impact of a number of major system-wide problems. Areas that need to be strengthened during subsequent MEDIPP cycles are the refinement of veteran population projections based on actual 1980 Census data and reevaluation of all cost figures submitted this year. While we are satisfied with the progress made this cycle to link program planning through MEDIPP with construction planning and budget formulation, the lack of a consistent approach by districts to resource allocation estimates requires a more solid interface between these areas in the future. While involvement of VA personnel was extensive this year, we need to strengthen community involvement, specifically service organizations, affiliates, and congressional staffs, in the future.

2. Given all the constraints inherent in the first year of a major strategic planning effort such as MEDIPP, we are very pleased by the level of analysis and documentation contained in the initial MEDIPP plans. Most proposals were based on quantitative justification. However, unresolved issues raised in initial plans must be further developed and issues that were not developed in detail this year must be studied and analyzed to reach the level of specific recommedations and proposed actions. Plans should also be reassessed in terms of population and bed changes within a longer planning horizon of 1995 and 2000. Such considerations could have a modifying influence on first cycle proposals before the full implementation of these MEDIPP proposals occurs.

3.(i) The data projections contained in the MEDIPP plans indicate there will be substantial increases by the year 2000 both in the number of veterans age 65 and older and the proportion of the veteran patient population that they represent. The number of operating beds to meet projected patient needs and the location of beds within the system to accommodate veteran migration patterns must be studied. A significant increase in the number of nursing home beds is indicated. This need will have to be met through construction of VA beds as well as increased utilization of community resources and State Homes.

3.(ii) The increased need for nursing home beds, emphasis on alternatives to hospitalization especially for the aged veteran, and increased development of outpatient and ambulatory care service are all recommendations contained in MEDIPP plans. These factors indicate that there may be some significant changes required in the type, mix and balance of services and the need to implement major mission changes at a small number of medical centers in order to ensure an equitable integrated distribution of VA health care services.

4. Mission changes considered during the initial MEDIPP cycle have primarily been proposals to close small surgical services and to convert several small general medical hospitals to nursing home care facilities. These changes have been made in response to the increased need for extended care facilities in most medical districts. Several of these proposals require further analysis and justification. We intend to proceed with the implementation of those mission changes which have been adequately justified after appropriate consultation with congressional committees and service organizations has taken place.

5.(i) The cost associated with the initial startup phase of MEDIPP were not specifically tracked. We intend to more closely monitor these cost during future cycles.

5.(ii) Some general indicators of the costs for the first years include the salaries and benefits for 87 full-time employees; $30,000 for two national training conferences; and $75,000 in travel expenses. Over 400 administrative and clinical personnel were involved in the deliberations and meetings required to develop the plans.

5.(iii) $15,000 has been spent on consultant fees.

NURSING HOME CONSTRUCTION PROJECTS

Question: In November 1981, VA formed a task force to propose, evaluate, and implement ways to reduce the construction costs of its nursing homes. The task force proposed about 60 measures to reduce the cost of a new 120-bed nursing home. Although VA did not accept all of the proposed measures, many were to be implemented on those FY 1982 nursing home construction projects where they would not delay the working drawings and on all FY 1983 projects irrespective of any delays.

Have you done all you can to reduce the cost of building nursing homes? Are you satisfied that the Office of Construction and DM&S were justified in not accepting all the task force's proposals?

Answer: The cost reduction proposals which have been accepted represent the collective considered judgment of both Office of Construction and DM&S. The mere fact that a proposal is made by a task force whose primary criterion is reduction of initial construction cost should not be interpreted to mean that other criteria, such as maintenance and operating costs and local variations in medical program needs, should be ignored. Where proposals were not accepted, it was because those other criteria were finally judged to outweigh the reduction in the estimated initial construction cost. Office of Construction now is undertaking a project to review all of its standards in the light of the current state-of-the-art in construction materials with a view to possible further cost reductions.

Question: What effect did these measures have on the FY 1982, 1983, and 1984 projects? How much did you save on the construction contracts? What delays did you experience?

Answer: The accompanying TABLE [redacted] indicates which proposals of the task force are being implemented on each project and their respective savings in estimated total project cost indexed to December 1982.

Question: To what extend have these cost reduction measures been incorporated into the design of other medical facilities? For example, the most substantial reduction comes from the use of a modular design concept for the nursing homes. Do you plan to use this concept in domiciliaries?

Answer: The cost reduction measures are being considered for incorporation into the design of other facilities where they are consistent with medical program requirements and are not outweighed by factors other than initial cost. When the VA policy regarding construction of new domiciliaries has been enunciated, all cost reduction measures consistent with that policy, and with the medical program requirements which derive from it, will be implemented.

Cost Reduction Items for Immediate Implementation

Nursing Care Homes

1. Omit provisions for vertical expansion. Provide capability only when specifically justified.

2. Adopt Modular Design Concept for Nursing Wings.

   (a) Eliminate 4-bed patient rooms.
   (b) Use 7'-0" length patient beds.
   (c) Reduce single patient room by 10 NSF.

3. Use the least expensive structural system compatible with the configuration of the building and the site. Consider wall bearing with roof joists.

4. Toilets and bathrooms.

   (a) Eliminate all showers and tubs in all private or shared bathrooms, connected to bedrooms.
   (b) Eliminate urinal in congregate bath.
   (c) Provide two full bathrooms per 60-bed unit to contain a tub, lavatory, and water closet in lieu of any bathrooms connected to a bedroom. Retain the congregate bathing facilites.
   (d) Configure bed structure for 60 beds with: six single bedrooms; two singles with private toilet; and four singles with shared toilets for each pair of rooms; and with 27 two-bed rooms, 26 will have a shared toilet for each pair of rooms; one will have a private toilet.

5. Reduce dining room space by 35%. Meals will be served in two sittings rather than one.

6. Reduce recreation room space by 35%. The recreation and dining areas will be adjacent so that the dining room may be used for recreational activities when meals are not being served.

7. In lieu of male and female toilets in lobby area for visitors, use one unisex with lavatory and water closet. Use similar single unisex toilet for dining room.

8. Reduce social work office from 120 NSF to 100 NSF.

9. Reduce maximum space for rehab/rec therapists from 200 NSF to 150 NSF.

10. Eliminate razor blade receptacles in toilets.

11. Use 3'-8" x 6'-8" doors in lieu of 3'-10" x 7'-0" in patient rooms.

12. Do not design exterior balconies at bedrooms.

13. All ceilings 8'-0" in lieu of 9'-0".

14. When station's trash disposal uses dumpster system, eliminate trash room.

15. Use design discretion to eliminate or reduce skylights.

16. Use design discretion to reduce glass areas.

17. Do not provide revolving doors.

18. Reduce stair landings to 3'-8" deep.

19. Do not provide connecting corridors or tunnels unless specifically justified.

20. Reduce capacity of hot water generator and storage tank consistent with data obtained in past and on-going field testing conducted by Mechanical Engineering Service.

21. Reduce quantity of electrical convenience receptacles in patient rooms.

22. In home-run conduit only, permit six electrical circuits.

23. Reduce electrical, signal, and telephone closet depth to 12".

24. Select least expensive method to obtain reduced lighting levels for appropriate areas.

25. Where an emergency generator is necessary, locate it outside of the building structure.

26. Provide emergency generator only when required by code, seismic or other justifiable need which cannot be satisfied in a less expensive manner.

27. Use 120/208 main distribution voltage in lieu of 277/480.

28. Minimum conduit size will be 1/2" diameter.

29. Omit TV antenna outlets in all patient rooms. TV outlets shall be installed in patients' lounges and recreation rooms. In patient bedrooms, TV's may be plugged into regular electrical outlets, using portable antennae.

30. Use conventional standard lavatory with gooseneck spout and wrist operated faucets for wheelchair access.

31. Delete ceramic tile in drinking fountain alcove. Substitute heavy duty vinyl wall covering instead.

32. Delete requirement for non-skid ceramic/quarry tile in toilets, utility rooms and other areas not subject to standing water and/or grease. Provide non-skid surface in bath/shower areas and food preparation/dishwashing areas.

33. Quiet Rooms:

(a) Provide one Quiet Room of 180 NSF in a single-level 120-Bed NHCU.
(b) Provide one Quiet Room of 180 NSF in a multi-level, 120-Bed NHCU on each level.
(c) Provide one Quiet Room of 180 NSF in a 60-Bed NHCU.

34. Delete drywall protection of roof structure.

35. Reduce landscaping by 50%.

ESTIMATED DOLLAR SAVINGS FOR NHCU COST REDUCTION ITEMS IMPLEMENTED

COST REDUCTION ITEMS	Northport FY 84 120-Bed	Providence FY 84 60-Bed	Hines, IL FY 83 120-Bed	Boise, ID FY 83 60-Bed	Denver, CO FY 82 60-Bed	Lake City, FL FY 82 120-Bed	Miami, FL FY 84 120-Bed
	T.P.C. 12/82	T.P.C. 12/82	T.P.C. 12/82	T.P.C. 12/82	T.P.C. 12/82	T.P.C. 12/82	T.P.C. 12/82
#1	N/A	N/A	N/A	40,000 P	72,200	163,700	N/A
#2	1,134,000	488,000	395,000 P	399,500	397,700	N/A	N/A
#3	38,000	N/A	N/A	10,000 P	13,400	N/A	N/A
#4	45,000	19,000	35,000 P	16,000	3,000 P	5,000 P	5,000 P
#5	Included in #2 above						
#6	Included in #2 above						
#7	Included in #2 above						
#8	Included in #2 above						
#9	Included in #2 above						
#10	1,500	600	1,340	500	500	1,100	1,100
#11	2,900	1,200	3,400	1,000	1,000	2,400	2,400
#12	N/A	N/A	N/A	N/A	N/A	N/A	N/A
#13	82,000	35,000	55,000	29,000	29,000	N/A	65,500
#14	Included in #2 above						
#15	28,000	12,000	N/A	N/A	N/A	N/A	N/A
#16	10,000	4,800	N/A	3,800	3,700	N/A	N/A

COST REDUCTION ITEMS	Northport FY 84 120-Bed	Providence FY 84 60-Bed	Hines, IL FY 83 120-Bed	Boise, ID FY 83 60-Bed	Denver, CO FY 82 60-Bed	Lake City FL FY 82 120-Bed	Miami, FL FY 84 120-Bed
#17	42,000	38,000	N/A	37,000	37,000	33,300	N/A
#18	N/A	N/A	1,200	N/A	N/A	N/A	N/A
#19	N/A	N/A	N/A	N/A	N/A	N/A	N/A
#20	1,100	500	800	400	400	900	900
#21	8,600	3,600	7,000	3,000	3,000	6,800	6,800
#22	1,100	500	800	400	400	900	900
#23	Included in #2 Above						
#24	33,000	15,000	25,000	11,500	11,400	26,000	26,000
#25 & 26	64,000	28,000	N/A	N/A	22,600	N/A	N/A
#27	13,500	6,000	N/A	N/A	4,600	10,400	N/A
#28	6,800	2,400	6,000	2,400	2,400	5,400	5,400
#29	10,000	4,800	9,900	3,700	3,700	8,500	8,500
#30	9,000	3,600	8,500	3,200	3,200	7,200	7,200
#31	660	360	900	300	300	800	800
#32	2,800	1,200	N/A	1,000	1,000	2,300	2,300
#33	Included in #2 Above						
#34	64,000	28,000	57,000	22,600	N/A	N/A	N/A
#35	34,000	15,000	N/A	11,800	11,700	26,600	N/A
HVAC	237,000	80,000	N/A	70,000	N/A	N/A	N/A
TOTAL	1,868,960	787,560	607,240	667,100	622,200	301,300	132,800

A. The Hines and Miami projects each consist of additional floors on top of existing building. Cost reduction items are partially implemented.

B. All of the above figures are based on the estimated values of the cost reduction items and are adjusted to the respective project locations.

C. "P" denotes partial implementation.

D. The above amounts are estimated cost savings. A detailed cost analysis could not be made because there are no specific "before and after" drawings.

QUESTION:

VA's policy to build nursing care facilities only adjacent to or near its VAMCs may result in added construction expenses due to topography, soil conditions, limited space, utilities, or other site-related costs. VA has had site preparation expenses for several 120-bed nursing care facilities to exceed $1 million.

(1) Why can't you select sites to build nursing homes more suitable for construction?

(2) When you plan to build a nursing home, do you identify all possible sites within the patient service area or medical district prior to selecting a location to build? If not, why?

(3) Do you have any study underway to identify ways to reduce site preparation cost? If so, when do you expect the study to be completed?

ANSWER:

(1) Current VA policy mandates that all new nursing home care unit (NHCU) construction be sited on existing VA medical center sites. This policy decision was based on the philosophy of the continuity of care provided to veteran patients and the ability of the medical center based NHCU to provide that care. Therefore, VA site selection for NHCU construction is limited to the available land at the medical center site. Within the limitations imposed by the medical center operational setting of our nursing homes and the availability of land at the respective VAMCs, we do attempt to select the nursing home sites which are more suitable for construction.

(2) VA site selection for NHCU construction is currently limited to existing VA medical center sites. The individual sites within a medical district are evaluated, but the VA currently does not evaluate off-site locations for construction.

(3) There is no ongoing study to identify ways to reduce site preparation costs. However, some suggestions made by the VA's nursing home cost reduction task force to reduce landscaping costs have been adopted and are being implemented. It should be emphasized that we endeavor to select the nursing home location at each VAMC which will result in the lowest possible construction cost.

QUESTION:

Congress directed VA to allow the Tampa, Florida; Fresno, California; and the Ann Arbor, Michigan VAMCs' directors to administer their own nursing home construction projects.

(1) How is that experiment coming along? What effect has this set-up had on the timeliness of constructing the homes? The cost? Has it affected DM&S and the Office of Construction's review and approval of the designs, working drawings, and actual construction?

(2) Did the VAMCs have the in-house capabilities to supervise construction projects of this magnitude? If not, did you provide the necessary expertise? If so, how many and what type of staff was detailed to provide technical assistance?

(3) Overall, what do you believe are the advantages and disadvantages to letting the VAMCs direct their own construction projects?

ANSWER:

(1) Construction contracts were awarded for the Ann Arbor project in November 1982 and Tampa project in December 1982. The anticipated award date for Fresno is May 1983. In FY 1983 to date, bids have been received on four VA nursing homes. The respective construction bids and other project costs for these four projects are tabulated below:

BID DATE	LOCATION	NO. OF BEDS	GSF	ACTUAL COSTS: CONSTRUCT. CONTRACT	CONTING'Y ALLOWANCE	TECH SERVICES	TOTAL PROJECT	$/GSF	$/BED	COSTS ADJUSTED TO DC INDEX @ 1/83: PROJECT COST TOTAL	$/GSF	$/BED
VA NURSING HOMES												
11/82	Ann Arbor,MI	120	52,976*	$5,128,000	$335,000	$546,000	$ 6,009,000	$113.43	$50,075	$5,230,750	$ 98.74	$43,590
11/82	Bronx,NY**	120	64,750	$8,756,000	$574,300	$750,000	$10,080,300	$155.68	$84,000	$8,410,720	$129.90	$70,090
12/82	Tampa,FL	120	54,126	$5,124,500	$334,500	$546,000	$ 6,005,000	$110.94	$50,042	$7,532,460	$139.17	$62,770
1/83	Lake City,FL	120	54,847	$3,926,950	$316,050	$500,000	$ 4,743,000	$ 86.48	$39,525	$6,363,110	$116.02	$53,025
AVERAGE			---	---	---	---	---	$116.67	$55,910	---	$120.99	$57,369

* Gross area shown for Ann Arbor is based on preliminary drawings prepared by VACO Office of Construction staff. Final working drawings not available at this time.

** The Bronx NHCU is an unusual project. The site conditions, connecting tunnel, trash and linen disposal system add $2,000,000 base construction or $16,000/bed total project cost. This project is designed in accordance with seismic requirements conforming with the design criteria of the new hospital and research building. Also increasing the cost of this project is the architectural blending of the NHCU with the old chapel which was retained on the site. The gross area of this building is approximately 10,000 sq ft more than normal, due to the interplay with the chapel.

The administration of the Tampa and Ann Arbor projects by their respective VAMC director does not appear, so far, to have significantly affected the cost of these projects or the timeliness of construction. Preliminary plans for all three projects had been completed prior to the delegation of the projects to the medical centers. There has been no other VACO review or approval of the designs or working drawings.

(2) At the request of the medical centers, O/C has assigned resident engineers to oversee the construction of the Tampa and Ann Arbor projects. A resident engineer also will be assigned to oversee the Fresno project when that project enters the construction phase. A total of eight O/C FTEE are or will be allocated to these projects as follows:

Ann Arbor	-	1 Senior Resident Engineer 1 Assistant Resident Engineer 1 Secretary
Tampa	-	1 Resident Engineer 1 Assistant Resident Engineer 1 Secretary
Fresno	-	1 Resident Engineer 1 Secretary

(3) The three delegated Nursing Home Care Unit projects seem to be progressing well at this time. At this juncture, the projects are essentially on schedule, within budget, and scheduled for completion in the Summer of 1984. Obviously, a full assessment of the success of these delegated Major construction projects can better be made once they are completed. In this regard, it is premature to judge the overall advantages or disadvantages of delegated Major projects.

Question 8: Newark Outpatient Clinic

On November 29, 1982, the Office of Inspector General reported that the Newark satellite outpatient clinic should be consolidated with the VA medical center at East Orange. The IG reported that such a move would not affect the volume or quality of care provided to veterans in that area and would save about $363,000 in annual lease expense and $307,000 in annual salaries, and would allow VA to avoid about $470,000 of planned construc tion at the Newark clinic. Both the medical center director and the Chief Medical Director agreed that something had to be done about the existing Newark clinic, but did not agree to consolidate the two clinics at the medical center.

(1) Has the Administrator reviewed this particular report? If so, has he decided whether to consolidate the two clinics?

Answer:

(1) The Administrator has not officially reviewed this report and there has been no decision to consolidate the two clinics. However, DM&S is conducting a study to determine the practicability of re-locating these services to the medical center in East Orange in lieu of leasing space near the main medical center building, which was previously considered.

QUESTION 9: Sizing of Surgical Suites

GAO recommended in 1981 that VA determine the number of operating rooms needed in a surgical suite using actual work data. Although VA disagreed with the specific model GAO proposed, VA agreed to incorporate GAO's concerns into a new model it was developing.

(1) What is the status of your new model for determining the size of surgical suites?

(2) Are you justifying any of your proposed construction projects on this new criterion?

ANSWER:

(1) A research project is underway at VAMC Ann Arbor to develop a "Surgical Management Information System". This project has an estimated completion date of April 1984. The results will be incorporated into new surgical criteria applicable to all proposed construction projects.

(2) Workload data is currently available for each VA medical center, including major and minor surgical procedures performed. This information is used in determining the appropriate number of operating rooms in proposed construction projects.

REPROGRAMMING OF SAVINGS ON CONSTRUCTION PROJECTS

Question: In the past, you have offset your funding needs for new construction projects with funds left over from prior years' appropriations. Last year, for example, you reprogrammed $32.7 million. With the economy the way it has been, and with the corresponding reduction in the inflation rate, I would imagine you have been realizing substantial savings on your construction contracts.

(1) By what amount have you reduced this year's construction funding request to recognize savings on prior years' projects?

(2) Would you provide a summary, for the record, of last year's projects where you received favorable bids and those where you had to reprogram funds to pay for contracts which were more expensive than you had budgeted?

Answer: The FY 1984 Major Construction request was offset by $79,006,000 from savings in the Major Working Reserve.

Thirty-one major construction projects were awarded during 1982. Only one required a cost increase for award; another had no difference; and twenty-nine received favorable bids. The list follows:

MAJOR CONSTRUCTION AWARDS - FY 1982

LOCATION	DESCRIPTION	BUDGET AMOUNT	REVISED EST COST	DIFFERENCE
Atlanta, GA	Warehouse & Engineer Office	$ 1,950	$ 1,831	$ -119
Bedford, MA	Smoke Partition	1,075	755	-320
Buffalo, NY	Renovate SPD	2,800	2,172	-628
Calverton Nat'l Cem.	Dev. 25 Acres & Svc. Bldg.	2,576	2,239	-337
Cincinnati, OH	Remodel/Expand Canteen	1,161	1,139	- 22
Dallas, TX	120-Bed Nursing Home	8,500	7,220	-1,280
Fayetteville, AR	Clinical Addition	4,500	3,879	-621
Fresno, CA	Correction of Seismic Def.	4,600	4,730	+130
Iowa City, IA	Fire & Safety Defic.	2,700	1,301	-1,399
Kerrville, TX	120-Bed Nursing Home Care	7,750	6,970	-780
Lake City, FL	Renovate SPD	1,201	897	-304
Long Beach, CA	Addn. & Renov. SPD	2,799	2,504	-295
Memphis,TN	Amb. Care Renovation	9,250	5,655	-3,595
Murfreesboro, TN	Safety & Fire Defic.	3,168	1,599	-1,569
New Orleans, LA	Exp.Clin. OP (PH 2)	67,650	67,650	0
North Chicago, IL	Fire/Safety Improv.	4,981	4,026	-955
Palo Alto(MPD), CA	Center Core Building	30,200	19,482	-10,718
Perry Point, MD	Sewage Treatment Plant	1,141	1,105	- 36
Philadelphia, PA	Clinical Improvements	1,993	1,485	-508
Poplar Bluff, MO	Seismic Defic.	10,550	8,264	-2,286
Quantico Nat'l Cem.	Dev. 75 Acres	8,188	5,767	-2,421
Salem, VA	Safety & Fire	4,502	2,529	-1,973
Sepulveda,CA	Fire/Safety	8,000	6,625	-1,375
Shreveport, LA	Safety & Fire Improv.	1,158	943	-215
Sioux Falls, SD	Reg. Office Act. Bldg.	2,700	1,606	-1,094
Togus, ME	Renovate Bldg. 207	5,100	2,602	-2,498
Tucson, AZ	Clinic Addn. for Lab.	20,850	13,244	-7,606
Washington, D.C.	120-Bed NHC & Cl. Fac.	24,600	21,941	-2,659
White City, OR	Renov. Consol R.H.S.	1,723	1,334	- 389
Wichita, KS	60 Bed NHC	4,800	3,450	-1,350
Wood, WI	Reloc. Nuclear Med.	1,700	1,163	-537

CHANGE ORDERS

Question: Last December you testified that VA was experiencing a change order rate of about 3.4 percent on major construction projects. In material submitted for the record of that hearing, GAO expressed some concern about the apparent increase in the proportion of change orders caused by design errors or omissions or by "uncontrollable acts." I understand that VA has some procedures to determine the liability of the design firm for these errors or omissions and, if warranted, to recover the cost of the change order from the design firm.

Why has the portion of change orders caused by design error or omissions increased?

Answer: We do not believe that design errors and omissions have increased. We are also uncertain as to the criteria GAO used in classifying change orders as design errors or omissions in their relatively small initial sampling.

Question: Have you been following these procedures regarding evaluation of design firms? If so, can you characterize the performance of the firms? What do you do about firms whose performance is deemed unacceptable? How often has that happened in the last year.

Answer: We are rigorously following our procedure for evaluation of Architect-Engineer design firms. We characterize the performance of Architect-Engineer firms at the completion of construction as outstanding, satisfactory, acceptable, marginal, and unsatisfactory.

Question: How much of the cost of change orders caused by design errors or omissions have you recovered from the responsible design firms?

Answer: Three firms were notified in FY 1982 of unsatisfactory performance. Several other firms were considered marginal, which in most cases was the result of one or more disciplines (e.g., architecture, electrical, etc.) ~~has~~ been found unsatisfactory. This information is retained in our files for future selection consideration. Recovery of change order costs for design errors and omissions must meet a criteria of negligence. In these cases, we must work closely with the General Counsel before taking recovery action. There were two such cases where recovery was sought in FY 1982 with recovery of $24,500. Four other cases are currently under consideration for recovery action.

QUESTION 11: Minneapolis VAMC

GAO has questioned the need for a VA fire station and nursing care beds at the Minneapolis hospital.

(1) Why is a fire station still included in the project? Why can't VA contract with the community for fire protection? Why does the existing fire station need to be replaced?

(2) What is the current occupancy rate at the Minnesota State Veterans' Home in Minneapolis? What are the State's current plans to expand the nursing home? Why does VA feel it is necessary to construct its own nursing home in Minneapolis despite the availability of State nursing care beds?

(3) Were these factors considered in the revalidation of the Minneapolis facility?

ANSWER:

(1) The fire station is still included in the project because the present fire station is located at Ft Snelling which is scheduled to be closed.

Progress on planning for construction of the fire station is being delayed, at this time, pending negotiations with the City of Minneapolis for fire protection.

The existing fire station can not be used for the replacement hospital because it is located at Ft. Snelling. However, the decision to replace this fire station is contingent upon the outcome of negotiations with the City.

(2) As of the end of the first quarter of FY 1983, the occupancy rate at the Minneapolis State Veterans' Home was 89%.

We have not received any applications from the State of Minnesota for assistance to expand the State Home. At the present time, applications for assistance throughout the system are planned through FY 1987.

The majority of veterans admitted to VA nursing home care have a need for intensive restorative measures of the total medical center treatment services and have little or no potential for placement in proprietory or State skilled nursing homes. The MEDIPP plans from Medical District 18 include 120 nursing home beds at Minneapolis as a resource to provide a 14 percent VA operated proportion of a 12 percent market share. This proportion is well below the 25-40 percent guidance provided to all districts and means that the Medical District already plans to use community and State availability to a greater extent than expected nationwide.

(3) The revalidation process included examination of the demogaphic analysis and projections of nursing home care needs of veterans in the Minneapolis area. This examination looked at the projected demand in relationship to available resources, including the State Veterans' Home.

PHYSICAL PLANT EVALUATION

Question: In a December 1, 1982, letter to the Subcommittee on HUD-Independent Agencies, Senate Appropriations Committee, the former Administrator expressed his concern about the accuracy and reliability of data upon which VA formulates plans for resources, facilities, and programs. He described several initiatives VA was undertaking to improve these data. One of these initiatives is a survey of the condition of the physical plant at the 120 VA medical centers built before 1970 for which systems deficiency information is most lacking. The survey would begin in FY 1984 (if funds were available) and take 1 to 1-1/2 years to complete.

Doesn't your Space and Functional Deficiency Identification (SFDI) system already give you this type of information?

Answer: The Space and Functional Deficiency Identification system has as its primary focus the comparison of existing space and functional adjacencies against criteria standards for meeting current and projected workloads. Although the SFDI system contains a physical plant component, the information included is primarily based on the judgments of technical experts, based on limited data available. The proposed physical plant evaluation will provide data in appropriate detail to enable program managers to make more complete judgments on the technical conditions of the physical plants of VA medical centers.

Question: If this type of information is so critical for prioritizing and justifying construction projects, why have you waited so long to do it?

Answer: This type of information is currently developed on a project-by-project basis, rather than for an entire station. The information gathered has become so important that the need to survey the entire VA medical system emerged.

Question: How much will this study cost? Will it be conducted by VA staff or a contractor?

Answer: The studies are expected to cost $8,500,000. They will be conducted by several Architect-Engineering firms in conjunction with local VA employees. Contract management will be handled by Central Office employees. Each contract is expected to cover several stations.

Question: Why can't you begin this survey now?

Answer: We could survey a few individual stations now, but there are no funds available for surveying the entire system.

QUESTION 13:

As you know, a new VA outpatient clinic has been proposed to be built on GSA property in downtown Los Angeles. The Chairman of the Senate Veterans' Affairs Committee wrote the Administrator on October 4, 1982, transmitting a copy of the remarks he made on the Senate floor on September 29, 1982. In referring to the $3 million appropriated for the design and site preparation for this outpatient clinic, Senator Simpson asked that a prospectus be furnished him and this Committee in relation to this project. This matter was again discussed at this Subcommittee's December 14, 1982, hearing at which time Mr. Salmond informed us of the delays that would be encountered. On March 7, 1983, the VA transmitted an "interim prospectus" on this new outpatient clinic Would you please explain what the "interim prospectus" means? B) Can you give a firm date on which the "final prospectus" will be in our hands?

ANSWER:

A prospectus is normally provided the Congress as part of the budget request and is based upon completed preliminary plans. Since preliminary plans have not been completed, the prospectus was referred to as "interim" in that some of the information such as total square feet required and the cost estimate are not as refined as they will be after further development.

The preliminary plans are scheduled for completion in November 1983. A final prospectus will be prepared at that time.

Question 14:

As Mrs. Holt has indicated, the contract for the construction of the new VA Medical Center in Baltimore could be let almost immediately, if the funds were available. In light of the depressed employment in this area, has any thought been given to seeking funds in order to get this project underway?

Answer:

During 1980 the Veterans Administration purchased a site and completed the design for the construction of a new VA Medical Center in Baltimore. In February 1981 this medical center project was rescinded as part of the Administration's ongoing review of trimming the Federal Budget. Meanwhile the VA has instituted a dynamic grass-roots strategic planning system. This process has been given the acronym MEDIPP - for Medical District Initiated Program Planning. The recent MEDIPP submission for the Medical District, including the Baltimore area, has focused attention on the veterans' health care facility needs in the 1990's. The agency is currently evaluating the needs of the Baltimore area in conjunction with this MEDIPP process and a decision is expected in the near future.

QUESTION 15:

Some time ago this Subcommittee asked that the Inspector General look into the contracts for psychiatric care in the Commonwealth of Puerto Rico and report the results to us. Can you tell us whether or not this audit has been completed; and if so, what were the results?

ANSWER:

The final report covering our audit at VA Medical Center and Regional Office Center at San Juan was issued February 22, 1983. Copies of the report were provided the House Veterans Affairs Committees.

Responding to items of indicated Congressional interest, the audit found that information provided by fee-basis psychiatrists or contract hospitals had no significant effect in establishing service-connected disability claims or degree of impairment. Nor was there any convincing evidence to show that long-term patients had been placed in contract facilities providing minimal levels of shelter and nourishment but not medical and/or psychiatric treatment.

Our review did however disclose a statistically abnormal number of service-connected psychiatric claims granted in Puerto Rico (4.3 percent of the veteran population vs. 1.1 percent VA-wide) as well as the high number of claims rated at 100 percent disability (55.5 percent vs. 24.3 percent VA-wide). This would indicate that a systematic reevaluation of ratings should result in significant reductions in rated degree of disability.

We also found that management improvements should be made in contract care and monitoring procedures as well as in the administration of hospital service contracts. A potential cost avoidance of $14 million might be realized through improved management actions.

Question 16:

The Subcommittee has learned about the deletion of the oxygen system from the already let contract to construct 120 nursing care beds at the Dallas VA Medical Center. This deletion was furnished the resident engineer on this project by letter dated January 1, 1983. Can you tell us why the oxygen system was deleted when it was estimated to save $62,387; and the contractor would have to be paid $28,968 to delete it from the project? Did the Department of Medicine and Surgery participate in this decision?

Answer:

The oxygen system has not been deleted from the project. When the initial plans for the VAMC nursing home care unit were developed, criteria stipulated that 20% of nursing home care beds would be provided with oxygen. Subsequently, it was determined that criteria be revised to furnish a minimum of 5% of nursing home care beds with access to oxygen. Thus, the oxygen system at VAMC Dallas was reduced from 20% to 5%.

The Chief Medical Director recommended to the Administrator that 5% be the designated percentage.

NURSING HOME CONSTRUCTION PROJECTS

Question: The Subcommittee would be interested in learning more about the cost of constructing VA nursing care beds versus that of constructing nursing care beds in the State Veterans Home Program. A staff member visited two newly constructed nursing care units in Marshalltown, Iowa, and Ardmore, Oklahoma. We have pictures depicting the superb quality of the construction of these two nursing care units. The total cost of Marshalltown was less that $40,000 per bed and Ardmore was just over $23,000 per bed. Your estimated cost of constructing nursing care beds over the last several years ranges from $75,000 to over $120,000 per bed. Can you explain to us why there is such a difference in the cost of constructing these two types of nursing care units, particularly since the VA has to approve the plans for each?

Answer: The cost figures cited for Marshalltown, Iowa, and Ardmore, Oklahoma, are not comparable with those cited for VA nursing homes. The tabulation below provides cost information from our records of several VA nursing homes and several state facilities. Please note that the figures quoted for Ardmore and Marshalltown are only construction contract prices at bid time, while the figure quoted for VA nursing homes, although we do not know their derivation, appear to be estimated total project costs. The tabulation explains the difference.

In FY 1983, to date, bids have been received on four VA nursing homes. The respective construction bids and other project costs, for these four projects and similar data for four state-grant facilities are tabulated below:

BID DATE	LOCATION	NO. OF BEDS	ACTUAL COSTS					COSTS ADJUSTED TO D.C. INDEX @ JAN. 83			
			CONSTRUCT'N CONTRACT	CONTINGENCY ALLOWANCE	TECH SERVICES	TOTAL PROJECT	$/BED	CONSTRUCTION CONTRACT TOTAL	CONSTRUCTION CONTRACT $/BED	PROJECT COST TOTAL	PROJECT COST $/BED
VA NURSING HOMES											
11/82	Ann Arbor,MI	120	$5,128,000	$335,000	$546,000	$ 6,009,000	$50,075	$4,463,860	$37,199	$5,230,750	$43,590
11/82	Bronx,NY*	120	$8,756,000	$574,300	$750,000	$10,080,300	$84,000	$7,305,760	$60,881	$8,410,720	$70,090
12/82	Tampa,FL	120	$5,124,500	$334,500	$546,000	$ 6,005,000	$50,042	$6,428,010	$53,566	$7,532,480	$62,770
1/83	Lake City,FL	120	$3,926,950	$316,050	$500,000	$ 4,743,000	$39,525	$5,268,320	$43,903	$6,363,110	$53,025
AVERAGE			---	---	---	---	$55,910	---	$48,787	---	$57,369
STATE-GRANT FACILITIES											
5/79	Boise,ID	80	$2,028,522	$ 53,333	$140,952	$2,222,807	$27,785	$ 2,878,676	$35,983	$ 3,154,385	$39,430
3/81	Ardmore,OK	100	$2,217,805	$101,350	$180,843	$2,499,998	$25,000	$ 3,020,650	$30,207	$ 3,404,997	$34,050
12/81	Augusta,ME	120	$3,416,000	$183,000	$873,000	$4,472,000	$37,267	$ 4,591,104	$38,259	$ 6,010,368	$50,086
2/78	Marshalltown IA	180	$6,929,664	$274,049	$466,187	$7,669,900	$42,611	$10,858,783	$60,327	$12,018,733	$66,771
AVERAGE			---	---	---	---	$33,166	---	$41,194	---	$47,584

* The Bronx NHCU is an unusual project. The site conditons, connecting tunnel, trash and linen disposal system add $2,000,000 base construction or $16,800/bed total project cost. This project is designed in accordance with seismic requirements conforming with the design criteria of the new hospital and research building. Also increasing the cost of this project is the architectural blending of the NHCU with the old chapel which was retained on the site. The gross area of this building is approximately 10,000 sq ft more than normal, due to the interplay with the chapel.

QUESTION 17:

Can you give us information on why the projects at Amarillo and Clarksburg, listed in your FY '83 to '87 five-year medical facilities construction plan, were not included in the fiscal year 1984 budget?

ANSWER:

The VA has recognized the need for a clinical project to correct existing functional, space and privacy deficiencies at VAMC Amarillo. A project "Addition/Renovation Clinical Support" was developed, and preliminary drawings were completed. The project as developed consists of a four-floor addition to house a modern Ambulatory Care Clinic together with clinical and support functions and beds. As part of the project scope, several services, including a 30-Bed Psychiatric Unit would be renovated in the existing hospital.

It became evident, that in order to incorporate all of the medical center's projected needs, based on the recent MEDIPP submission, that the scope of the work would need to be redefined, thus prompting re-design. For instance, MEDIPP is recommending a 15,500 increase in outpatient visits for the period 1980 to 1990. It is because of this needed re-design, that the project was delayed to FY 1985.

The Clinical Addition and Alterations project at Clarksburg was originally scheduled for fiscal year 1984. However, due to a scope change and new workload projections, the project was not sufficiently developed for inclusion in the FY 1984 budget. Currently, the conceptual designs of the project are completed and preliminary drawings are scheduled for completion in September 1983. If this schedule is maintained, the project will be ready for consideration in the FY 1985 budget.

SUBJ: Funds for Replacement Medical Center at Minneapolis, MN

Question: The VA requested and received $15 million in 1981 for site development for the Minneapolis hospital. Why was the project then not included in the FY 82, or at least the FY 83 budget?

Answer: The approved FY 1981, budget included $15 million for design. A design contract was awarded on May 1, 1981. In August 1982, a contract was awarded for construction of a temporary clinic building, demolition of buildings on the site and other site preparation work. This work must be complete before construction of the new hospital can be started. It is expected to be completed in September 1983. In the meantime, design of the hospital building is progressing on schedule for a construction contract award in October 1983. Funds were not requested in FY 1982, or FY 1983, because it was not possible for us to utilize them before October 1983.

Question: Why is the VA's timetable for the Minneapolis project on the "slow track?" According to those involved at the local level, it is the VA who wants the slow rate of progress.

Answer: Some of those involved at the local level are aware that the design for the first major construction contract will be completed in July 1983. They have assumed that we would not take any further action until October 1, 1983, when funds are available. This is not the case. The drawings and specifications will be issued for bids as soon as they are completed. Approximately six weeks will be allowed for contractors to prepare their bids. These bids will be received by the VA in September 1983, and the contract will be awarded in October 1983.

Question: If pushed, how much could the VA actually speed the project up?

Answer: The schedule for design is coordinated with the schedule for completion of the site preparation work. Without a significant improvement in both aspects of the work, there can be no improvement in the overall schedule. It is not feasible to speed up the project.

BLINDED VETERANS ASSOCIATION
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STATEMENT OF NATIONAL PRESIDENT ELLSWORTH L. SHARPE
OF THE BLINDED VETERANS ASSOCIATION BEFORE A HEARING
OF THE U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
MARCH 16, 1983

Mr. Chairman and Members of the Subcommittee:

I am very pleased to have the opportunity today to appear on behalf of the Blinded Veterans Association before the Subcommittee on Hospitals and Health Care as part of these oversight hearings on the VA's medical construction program.

Since this is our first appearance this year before this subcommittee, I would like to congratulate Chairman Edgar on becoming the new chairman of this subcommittee. I would also like to congratulate those new members of Congress who now serve on this subcommittee.

For those members of Congress unfamiliar with the BVA, the association was founded in 1945 and chartered by a special act of Congress to represent blinded veterans. Our programs and activities emphasize seeking out blinded veterans where they live in order to encourage and assist them to assume an active role in life. We conduct a field service program to help blinded veterans where they live in order to encourage and assist them to assume an active role in life. We conduct a field service program to help blinded veterans develop satisfying careers. The field representatives in both programs are blinded veterans. The BVA is committed to provide whatever assistance is needed to help our fellow blinded veterans live productive lives despite their visual disabilities.

As such, we are concerned with the delivery of adequate health care services to our blinded veterans. Many of the most significant issues confronting veterans in the decade of the '80s will be the availability of

adequate health care services. The aging of the veterans population will intensify the need for quality health care services. Although the veterans' population might be on the decline, the health care needs of our nation's veterans continue to increase dramatically. Essentially, this subcommittee will be the forum for a consideration of these issues in the years to come.

The growing need and demand for health services, for the most part, have outdistanced the capacity of the VA medical system to respond adequately to the veterans population. It has been this demand which has sparked the controversy and debate in recent years on the VA's medical construction program.

Delays in the development of a comprehensive medical construction program have not helped to resolve the health care needs of our nation's veterans. In fact, such delays have only served to aggravate the problem further. As this issue has unfolded in Congress over the last year, it has become apparent that delay only breeds delay. The more time which is allowed to transpire without a resolution of the problem, the more acute the problems become and the more expenses are incurred to resolve the problem.

We know that the time of this committee is limited today and that its agenda is quite extensive. As such, we will limit our remarks today to a construction need that we feel has gone unresolved for too long. This is the need for a blind rehabilitation clinic in Puerto Rico.

On February 16 this subcommittee conducted a hearing on the health care needs of veterans in Puerto Rico and the Virgin Islands. The hearing focused on a report by the VA's Department of Medicine and Surgery requested by Congress.

This report cited the glaring need for improved and expanded medical

facilities in Puerto Rico. Comments by other veterans' groups, the VA, and members of this subcommittee suggested that the report identified needs which had been apparent for some time; therefore, the report, itself, was not too surprising.

However, one item in the report is astounding--not by its inclusion, but rather by its noted absence. Nowhere in the report entitled "A Plan for the Delivery of Health Care to Veterans in Puerto Rico and the Virgin Islands" is there any mention of the need for a blind rehabilitation facility or, in general, the needs of blinded veterans. The report's alternative recommendations do not include any related specifically to blinded veterans.

Yet, we are aware of previous reports within the VA which cite the need for a blind rehabilitation facility in Puerto Rico. And more importantly, we are aware from our own experiences of the need for a blind rehabilitation facility in Puerto Rico.

There are approximately 600 veterans in Puerto Rico who receive either pension or compensation from the Veterans Administration for blindness. Our experiences with statistics from the VA indicate generally that less than one-half of all blinded veterans are listed as receiving VA benefits for blindness. Therefore, we believe that there are considerably more than the 600 blinded veterans in Puerto Rico listed by the VA.

Experience has taught us that veterans are reluctant to leave their home environments to attend a Blind Rehabilitation Center or clinic. One of the most important functions of the BVA is assisting the blinded veteran who might be so reluctant. We assist the blinded veteran in developing the motivation necessary to leave his home and travel to one of the facilities. However, the problems associated with our Puerto

Rican veterans are much more difficult.

Our Puerto Rican veterans are very reluctant to leave their homes because they must travel a greater distance to the mainland. Language barriers, differences in customs, and differences in climate make it very difficult for a blinded veteran to participate in a blind rehabilitation program on the mainland. Additionally, it is important to remember that blind rehab facilities already are in great demand, so there already is an existing need for additional facilities.

We also know from experience that Puerto Rican customs do not encourage handicapped people to become more self-sufficient. Yet, we know from experience that a veteran must have the sense of self-sufficiency if he is to develop the skills and attitudes necessary to live with his visual disability. The absence not only of a VA facility for blind rehabilitation, but also the absence of an accredited civilian alternative, make the problem even more acute in Puerto Rico.

Yet, the recent hearing before this subcommittee indicated that no construction was planned for Puerto Rico until 1986 at the earliest. A blind rehab clinic in Puerto Rico has been included as part of the VA's five year plan in recent years. However, such a facility still awaits initial approval. Approval, itself, does not mean that a facility will open at that time or even shortly thereafter. Establishment of a fourth blind center in the southeastern U.S. was approved in principle in the late 1960's. However, that facility did not open until October, 1982. Quite frankly, the blinded veterans in Puerto Rico cannot afford to wait another twenty years.

We believe that a construction program for Puerto Rico should be speeded up. The recent report to Congress on the health care needs of

veterans in Puerto Rico provided the necessary documentation for such action. Also, any expansion of existing facilities or construction of new facilities should include a blind rehabilitation clinic.

We believe that the requirements for a blind rehab clinic would be minimal. It is our belief that as few as ten beds would contribute significantly to resolving the needs of our blinded Puerto Rican veterans. Additionally, the VA has suggested in the past that a staff of eight would be required for the clinic.

We are prepared to work with this committee and the VA to advance the need for such a facility in Puerto Rico. We believe this need to be a critical one and we believe that the VA should take action this year to begin the process which will eventually lead to the opening of a blind rehab facility in Puerto Rico.

The VA has been collecting data on this issue for years. The VA has the necessary information already which establishes the need for such a facility and how such a facility could be staffed. The time for studies and site inspections has ended. It is now time to take the administrative steps necessary to open a facility in Puerto Rico.

Enough time has passed. The rehabilitative needs of enough veterans have gone unserved for too long. We will continue to do whatever we can to press this issue further. The BVA will address this need again when we present our legislative program on March 17 at a Joint Session of the House and Senate Committees on Veterans Affairs.

Thank you very much for your attention today. I will be very happy to answer any questions you might have.

STATEMENT OF
CHARLES E. JOECKEL, JR.
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 16, 1983

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than three-quarters of a million members of the Disabled American Veterans, I am pleased to appear here today, Mr. Chairman, to present our views on the VA's Construction Program.

As you know, the VA's request for construction programs in Fiscal Year 1984 calls for funding of $868 million, of which, $808 million is devoted to the replacement and modernization of the VA health care system. Highlights of the Medical Construction Program include:

$86 million for outpatient improvements;

$41 million to meet fire and safety codes;

$94.6 million in clinical improvements;

$332 million in modernization and replacement projects;

$206 million in renovations, conversions and improvement in support services; and

$67.3 million to increase VA's nursing care capabilities.

MEDICAL CONSTRUCTION PROGRAM

As we pointed out in our testimony before the full Committee a month ago, Mr. Chairman, the DAV is pleased that the VA budget for Fiscal Year 1984 calls for the addition of a new geriatric research and educational clinic center and an expansion in nursing care beds of 300 next year. In addition, funding requests for new construction and conversion of existing facilities will result in 840 new nursing care beds in the system.

However, Mr. Chairman, of the $808 million in VA health care construction, only $67.3 million is set aside for nursing home care. Accounting for most of the 58% increase in construction funding for Fiscal Year 1984, is the scheduled replacement of the Minneapolis VA Hospital and the renovation, modernization and building additions at several health care facilities. In this regard, the DAV wholeheartedly supports the VA's efforts to replace and modernize its older facilities.

While we support full funding of the VA's request for construction programs, we are, nevertheless, concerned over the VA's effort to meet its most pressing demands on the health care system.

According to VA statistics, there are today over 3.3 million veterans age 65 years and older. By 1990 this figure is expected to rise to 7.7 million and to 9 million by the year 2000. Yet,

with all of its resources, including 9,600 nursing care beds available in the system, the VA cannot meet its current demand.

Mr. Chairman, we are also concerned over the maintenance of acute care beds for the care and treatment of elderly veterans. Yet, the Fiscal Year 1984 budget projects the loss of 800 more acute care beds next year. This proposed reduction will bring the total loss of acute care beds within the system to 5,100 since 1980.

In our view, the continual shutdown of beds, wards and certain sections of VA hospitals is a waste of resources. Considering the current demand on the system for nursing home care, and the rate at which new nursing beds are being added to the system, we think that more attention should be directed toward the possible conversion of beds already closed in the system to nursing care units.

Further, in view of the ever-increasing number of closures of acute care beds, we think that the Subcommittee should give serious consideration to amending Section 108 of Public Law 97-72 to establish a minimum number of acute care beds which shall be available within the VA health care program. In our view, the continual shutdown of acute care beds will relegate the medical care program to a caretaker system for elderly veterans.

Our concern, Mr. Chairman, centers around the acute care needs of the elderly veteran, of course, but what of the similar needs of the more than eight million Vietnam Era veterans whose average age by the year 2000 will be 53 years?

CONVERSION

While the VA is, according to testimony presented to the Senate Veterans Affairs Committee, considering the conversion of a few acute care beds within hospitals, their plan is directed more at "change of missions" -- conversions of entire hospitals (testimony attached).

Mr. Chairman, appended to my statement is an article which appeared in the January 13, 1983 edition of the New England Journal of Medicine entitled, "Why Acute Care Hospitals Must Undertake Long-Term Care." In their treatment of the subject, the authors point out:

> Acute care hospitals should re-orient their patterns of care. Unlike other providers, hospitals could offer comprehensive case management of patients, from home care to acute care, thus insuring continuity of services. Pilot projects, such as the Urban Medical Group in Boston, have shown that a comprehensive approach to caring for the chronically elderly can be cost-effective. Hospitals could most readily provide the physician care needed to eliminate the costly shuttle from nursing home to acute care facilities. Moreover, hospitals with long-term care beds would have a tremendous incentive to use those beds preferentially for patients requiring long-term care, particularly those inappropriately and expensively occupying acute care beds.

Mr. Chairman, the DAV will not, in every instance, oppose the VA's plans to change the missions of certain VA hospitals. However, our support will be predicated upon the proper maintenance of acute care beds in the system, a continued commitment to outpatient care, and the utilization (conversion to extended care) of beds already closed in the system.

MEDIPP

A little over a week ago, Mr. Chairman, the various veterans' organizations were briefed on the VA's Medical District Initiated Program Planning (MEDIPP) effort. As we understand it, MEDIPP is a model on which the VA plans to assess its future needs based upon a medical district perspective and the shift in veteran population.

Similar to the VA's current five-year plan, the goal of MEDIPP seeks to:

establish a health care delivery plan which views all facilities within a district as a part of a district-wide system;

make the most effective use of all available resources;

provide for the distribution of health care services among facilities within a district so that eligible veterans can receive all necessary care within a district; and

provide a valid base on which to propose necessary changes to achieve these and other goals.

While the DAV disagrees with the guidance provided to each Medical District concerning the bed sizing model and veteran population statistics, we support the VA's overall effort to allow the districts to individually determine their needs and provide suggestions on the most effective utilization of their facilities.

VA officials at Central Office are currently studying the recommendations from the 26 Medical Districts and have made no final decisions. However, we believe that the input from the local stations will assist the VA in future planning of:

* Adjustments in services to a level of need based on veteran population;
* Conversions of unused and under-utilized beds to extended care beds;
* Alternatives to institutional care;
* Adjustments in construction to meet the level of need of veteran patients.

In addition, the process will:

* Strengthen the decision-making process within the Department of Medicine and Surgery;
* Enhance communications between VA Central Office and local field stations; and
* Provide an opportunity for veterans' organizations and veteran patients themselves to participate in the formulation and review of plans.

Considering some of the proposed recommendations contained in the MEDIPP plan, we believe the model will serve as an effective tool in assessing the future needs of the VA health care program. Short of an endorsement, Mr. Chairman, the DAV supports the VA's efforts to make the most cost-effective use of the resources and funding available to it.

THE PRESIDENT'S PRIVATE SECTOR SURVEY ON COST CONTROL

Mr. Chairman, the DAV has recently obtained a draft copy of the President's Private Sector Survey on Cost Control, which makes several recommendations regarding the VA's Medical Construction Program. The Task Force of Federal Hospital Management, in their segment entitled "The Veterans Administration Health Care Facility Construction Program," makes, among others, the following conclusions and recommendations:

Conclusions:

1. Convert under-utilized medical, surgical and psychiatric beds in VA hospitals into nursing care beds;
2. Contract with the private sector for any additional beds needed; and
3. Simplify and streamline the extraordinary policies and procedures of the VA Construction Program.

Recommendations:

1. The VA should stop the construction of nursing beds and convert thousands of under-utilized beds to extended care;

2. Private nursing home operators should be contracted to build and operate nursing homes in cities where VA beds are needed; and

3. The Office of Construction should be reorganized.

Although there are other recommendations contained in the survey, Mr. Chairman, we believe the VA's effort with respect to MEDIPP meets many of the Task Force concerns. Without commenting specifically on the conclusions and recommendations regarding the Office of Construction, the VA has recently begun to focus on the possible conversion of beds within the system. While we believe the VA should give closer attention to this issue, the information appended to my statement together with the possible change in missions for certain VA hospitals alluded to in the MEDIPP model, clearly shows that the Department of Medicine and Surgery in considering such plans.

However, Mr. Chairman, we strongly disagree with the Task Force recommendation that the VA should stop building nursing homes and contract with private operators to build and operate new nursing facilities. Rather, we favor a plan which provides for both the conversion of beds and construction of new facilities. In this fashion, the VA can meet its current demand for nursing home care brought about by the aging World War II veteran population and meet its future needs to provide overall health care to Vietnam Era veterans.

Although the number of veterans over the age of 65 is expected to decline after the year 2000, in just thirty years from now, Mr. Chairman, the figure will increase again as over eight million Vietnam Era veterans reach 65 years of age. In our view, the commitment to provide care to these veterans is a responsibility of the VA that should not be abrogated -- thus requiring this group of veterans to fend for themselves in their advanced years.

SUMMARY

In summary, Mr. Chairman, the DAV supports full funding of the VA's Fiscal Year 1984 request for its health care construction program. We support a program which calls for the conversion of beds already lost to the system within VA hospitals and the continued commitment of the VA to meet the health care needs of all veterans of all age groups. We believe that the acute care beds available in the system are dangerously low and that every effort should be made to maintain the current level of acute care beds with an eye toward increasing these numbers in the years ahead. Finally, while the DAV supports the conversion of many of its unused beds, we do not favor VA contracting of its responsibility to provide overall health care to all segments of the veteran population.

This concludes my statement, Mr. Chairman, and I again wish to thank you and the members of the Subcommittee for allowing us this opportunity to present our views on this very important subject.

* * *

SPECIAL ARTICLE

WHY ACUTE-CARE HOSPITALS MUST UNDERTAKE LONG-TERM CARE

EDWARD W. CAMPION, M.D., AXEL BANG, AND MAURICE I. MAY, M.S.H.A.

FROM 1970 to 1980 the elderly population (those over age 65) grew by 14.8 per cent in Massachusetts and by 27.3 per cent in the country as a whole. The population over the age of 85 — 22 per cent of whom are institutionalized in the United States — grew by 53 per cent in the state and by 48 per cent in the United States.[1] This "graying of America" promises to continue (Table 1) and will radically change the future patient mix in acute-care hospitals. By 1978 the elderly accounted for more than 48 per cent of patient-days in Massachusetts acute-care hospitals, and this percentage is rising (Table 2).[2]

STRAINS ON THE SYSTEM

Although the patient mix has changed, patterns of care have not. Hospitals have continued to increase the intensity of services to a point that has become distinctly uncomfortable economically and politically. Only now are acute-care hospitals beginning to broaden their philosophy of care to incorporate the long-term medical, rehabilitation, and social needs of the elderly. There are multiple barriers to hospitals' shifting into long-term care, not only in reimbursement but also in the traditional patterns of teaching and practicing medicine in acute-care institutions. Despite these barriers, we believe that acute-care hospitals should move into the field of long-term care and that such a shift will result in improved delivery of health care to the elderly and in more efficient use of health resources.

Acute-care hospitals are currently feeling the consequences of severe economic difficulties experienced by the traditional providers of long-term care: chronic-care hospitals, mental-health hospitals, nursing homes, and home health agencies. The result is a burgeoning number of chronically ill elderly who do not seem to fit into any level of care. These elderly are becoming the "boat people" of the health-care delivery system. On any given day in Massachusetts 823 elderly patients[3] who do not need hospitalization are nevertheless occupying beds in acute-care hospitals, while awaiting placement. Annually, such patients account for over 300,000 patient-days in this state alone. This placement bottleneck can be attributed to the large number of patients with needs greater than nursing homes can meet and to the virtual freeze on nursing-home construction across the country.[4] The shortage of nursing-home beds is tied to problems that pervade the elderly-housing market and the home-health-care system. Although it is estimated that 15 to 40 per cent of the elderly in nursing facilities could be more appropriately cared for in private homes,[5] most no longer

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Table 1. Selected Data from the 1980 U.S. Census of Population.[1]

Age	Massachusetts Population			United States Population		
	1970	*1980*	*% change*	*1970*	*1980*	*% change*
0–14	1,567,823	1,173,281	−25.2	57,899,831	51,282,469	−11.4
15–64	3,485,162	3,837,225	+10.1	125,246,593	149,678,232	+19.5
65–74	381,011	422,615	+10.9	12,435,456	15,577,586	+25.2
75–84	203,724	230,008	+12.9	6,119,145	7,726,826	+26.3
>65	632,943	726,531	+14.8	20,065,502	25,544,133	+27.3
>85	48,208	73,908	+53.3	1,510,901	2,239,721	+48.2
Total	*5,685,928*	*5,737,037*	*+0.9*	*203,211,926*	*226,504,825*	*+11.5*

have a home, are entirely alone in the world, or are ineligible for home-care services. Home health care has traditionally been a low priority of Medicaid and Medicare, receiving less than 2 per cent of those budgets. In Massachusetts there are also 34 long-term-care hospitals with 6452 beds. Regulators are currently attempting to close some of these hospitals or convert them to nursing homes.[6] If they succeed, even more elderly patients in need of extensive care will become long-term residents in acute-care hospitals.

The problems exemplified in Massachusetts are national in scope. The American Hospital Association has recently established an office on aging and long-term care to "help hospitals face the challenge of adapting to meet the needs of their older patients and others with chronic conditions." In 1981, in response to these pressures, the Massachusetts Hospital Association established a multidisciplinary task force on long-term care to examine the role of hospitals in meeting future long-term-care needs. The report of the task force provides the framework for this article. Although we were members of the task force, the opinions expressed here are our own. Our principal conclusion and that of the task force is that acute-care hospitals must move to undertake long-term care.

The Nature of Nursing Homes

Since the advent of Medicare and Medicaid in 1965, the nursing home has become the centerpiece in the long-term-care system in the United States. There are 1.3 nursing-home beds for every acute-care bed in the United States. Eighty-six per cent of nursing-home residents are over 65, and about one quarter of all elderly Americans will spend part of their life in a nursing home.[7] The growth in nursing homes has been accompanied by increasing concern about their impact on residents. Once in a nursing home, the elderly generally become physically, emotionally, and economically dependent on the home for the rest of their lives. After only a few months in the home, most residents have used up their personal savings; they have become impoverished and are entirely dependent on Medicaid. Eighty per cent of nursing-home beds are occupied by patients receiving Medicaid, according to the Massachusetts Federation of Nursing Homes. Discharge is usually impossible for these people even if their health improves, since they have no means of support in the outside community. Coordinating successful community discharges for these vulnerable persons is a complex, time-consuming, and risky task. Moreover, at present there are no financial incentives for nursing homes to do so. Knowing this, nursing-home staff do not emphasize — and cannot afford to emphasize — rehabilitation and community placement.

Nursing homes have also become a repository for psychiatric patients, drastically changing the nature of care in many homes. A 1981 report by the Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts stated that 10 per cent of nursing-home residents were admitted from psychiatric facilities, and another 24 per cent were classified as having mental illness (excluding dementia), mental retardation, or major behavioral problems. The influx of mental-health patients results from the closure of three large psychiatric facilities, with a drop in the state mental-health inpatient census from 14,500 in 1967 to 2100 in 1981.[8] The Massachusetts experience exemplifies the national situation.[9]

Policy makers see an urgent need for more nursing-home beds despite the difficulties of financing and controlling access. Report 36 (January 1981) from the Massachusetts Department of Public Health's Determination of Need Office shows a need for 7300 more nursing-home beds in the Commonwealth by 1985. However, the growth of nursing homes is stalled, because present state reimbursement policies make capital financing and ownership economically unattractive in this predominantly for-profit industry. There has been a net increase of only 961 beds in the past five years, and few new homes have been scheduled for construction. Nationally, there is also an effective freeze on nursing-home construction, coupled with restrictive Medicaid reimbursement. It is not only the shortage of nursing-home beds that backs up patients in acute-care hospitals. Because of the economic incentives of nursing homes, the elderly patients who require more attention are kept in acute-care hospitals. Patients who require minimal care and thus little staff attention are more attractive economically, and pri-

Table 2. Six-Year Trend in Days of Care for the Elderly (>65 Years) as a Percentage of Total Days of Care for All Patients in Acute-Care Hospitals in Massachusetts.*

Source of Data	Days of Care for Elderly (% of Days of Care for All Patients)					
	1974	*1975*	*1976*	*1977*	*1978*	*1979*
Massachusetts Hospital Association	41.6	43.1	46.3	46.3	48.4	—
Massachusetts Department of Public Health	—	—	—	49.7	51.4	50.9

*The data for these two time series were obtained from different sources and thus differ slightly, although they show the same trend. The data from the Massachusetts Department of Public Health are from a survey of most hospitals in Massachusetts, whereas the Massachusetts Hospital Association data represent actual discharges from representative hospitals.

vately paying patients are most attractive of all. An astonishing absence of physician involvement in nursing homes further discourages acceptance of patients who require extensive care and are dependent on Medicaid.

There are broader societal changes that contribute to the pressure to institutionalize the elderly. Increasing numbers of women are joining the work force, reducing the number of women who can care for elderly relatives at home. Family size is also declining. Mobility in the work force has created a geographic separation of children from parents, making care logistically difficult. The increases in the divorce rate and in the number of single-parent families have further complicated familial care of the elderly. Moreover, progressive inflation has eroded the savings and pensions of the elderly, diminishing their capacity to remain economically independent in the community.

The Challenge for Hospitals

Unarguably, the hospital has stood as the primary point of contact in the community for meeting the acute health-care needs of the elderly. It remains virtually the only community institution that is open 24 hours a day, 7 days a week, to provide emergency care and social and rehabilitation services. This is important to the elderly, who are more vulnerable to illness, stay longer in hospitals, and are admitted more frequently than other age groups. In 1978 persons over age 65, representing 12 per cent of the Massachusetts population, accounted for 28 per cent of hospital discharges.[10] The average length of stay in Massachusetts acute-care hospitals was 6.9 days for patients under 65, 12.5 days for those aged 65 to 75, and 14.5 days for those over 75.[11] Elderly patients are readmitted more frequently in the course of a year, and a small percentage of them accounts for a disproportionately large number of patient-days.[12] For the country as a whole, data from the Health Care Financing Administration indicate that 70 per cent of annual expenditures are used to care for a mere 8.8 per cent of Medicare beneficiaries.[13]

In spite of the large numbers of elderly patients in acute-care hospitals, most of these institutions have no comprehensive geriatric program geared to the long-term medical, rehabilitative, and social needs that are linked to acute illness. To provide quality care, hospitals must make a commitment to long-term care for the chronically ill elderly patient. It is becoming apparent that no one else will or can.

If hospitals were to provide more long-term-care services, fundamental changes in the hospital environment and in reimbursement would be required. Acute-care hospitals lack areas where patients can congregate for meals or for recreational and social activities. The rapid turnover of patients in acute-care hospitals is unsettling to older persons, who need stability, patience, and friendship. Hospital staff have not been trained to care for the long-term needs of the elderly. In the acute-care hospital environment rampant testing and ancillary procedures can result in the "overmedicalization" of patients and can exacerbate the problem of escalating health-care costs. An option for acute-care hospitals would be to develop long-term-care units specifically for such elderly patients. In Massachusetts, however, the state rate-setting commission has developed reimbursement methods that prevent hospitals from operating long-term-care units. If these methods were changed so that the costs of long-term care could be isolated from overhead for acute care a long-term-care unit would be economically viable. Recent federal regulation that permits small rural hospitals to operate "swing beds" for chronic care is a move in this direction.

Acute-care hospitals should reorient their patterns of care. Unlike other providers, hospitals could offer comprehensive case management of patients, from home care to acute care, thus ensuring continuity of services. Pilot projects, such as the Urban Medical Group in Boston, have shown that a comprehensive approach to caring for the chronically ill elderly can be cost effective.[14] Hospitals could most readily provide the physician care needed to eliminate the costly shuttle from nursing home to acute-care facility. Moreover, hospitals with long-term-care beds would have a tremendous incentive to use those beds preferentially for patients requiring long-term care, particularly those inappropriately and expensively occupying acute-care beds.

Using existing sources of state, federal, and foundation funding, hospitals could coordinate or sponsor a wide array of institutional and community services for the elderly: congregate housing; nursing-home, day, home, foster, hospice, and "respite" care (care to offer a respite for those providing care at home); meals on wheels; and health education and screening. Some of these services, such as nursing-home care, day care, and home health care, are supported by Medicaid in Massachusetts; a smaller number are reimbursable by Medicare. To limit their liability and protect themselves financially, some hospitals are reorganizing their corporate structures and creating holding companies to oversee such programs.

The financial risks of providing community and long-term care are smaller than hospitals fear. Already 15 Massachusetts hospitals have certified home health agencies. Nationally, private entrepreneurs continue to find the $21 billion nursing-home industry profitable, though largely by catering to private payers, who contribute $7.5 billion to the industry.[15] With efficient management, quality nursing-home care is possible. Hospitals could also take unique advantage of economies of scale. Most important, only acute-care hospitals could reap additional economic benefits from a more efficient use of acute-care beds.

Hospitals are becoming increasingly cognizant of the long-term-care system, simply because their economic survival may depend on it. As cost-control efforts put the pinch on nursing homes, the acute-care hospitals will feel the squeeze. Severely impaired,

hard-to-place elderly patients account for most "administratively necessary days" for which hospitals have been paid less than the full per diem rate. The growing numbers of such patients threaten the financial viability of some hospitals.

The financial benefits deriving from long-term care will become particularly appealing to acute-care hospitals if the trend toward prospective reimbursement continues. With hospitals held directly liable for cost control, comprehensive management of the patient requiring extensive care in a long-term unit or at home becomes cost effective. For example, the physician's home visit currently appears to be costly and inefficient. However, as part of a comprehensive system of health care for the elderly, home visits would be recognized as an effective means of providing high-quality, low-technology care that would also prevent expensive institutionalization. Only hospitals have the knowledge and incentives to direct such resources to the elderly who are truly at risk for costly hospitalization.

Acute-care hospitals are finding themselves stumbling into long-term care with no clear strategy.[16,17] To ameliorate the problem, some have established closer ties with local nursing homes by providing in-service education, consultation, and even medical coverage. Some hospitals have actually become long-term-care facilities, entirely or in part. Others have developed close administrative ties to local nursing homes as a means of gaining influence in decisions concerning bed use and patient transfers. A few large hospitals have simply and quietly purchased nursing homes and now run them. The objective of all these activities by acute-care hospitals is to gain greater access to long-term-care beds.

The lack of access to long-term care creates dangerous pressures on administrators and physicians to manipulate the utilization-review process or even patient care in order to keep patients defined as acutely ill and thereby covered by Medicare. Exposed to this small group of severely impaired patients in teaching hospitals, residents and medical students may acquire a distorted and pessimistic view of aging, entirely losing sight of the fact that 95 per cent of the elderly reside at home.[18]

As acute-care hospitals assume responsibility for long-term care, they must become more effective agents in preventing institutionalization of the elderly at risk. This means moving decisively into community geriatric care, which is currently a tangled array of medical, social, and economic services badly in need of coordination. Hospitals have learned that crisis and collapse in any of these community services may result in increased numbers of hospital admissions, long-term institutionalization, and increased costs.

More effective preventive interventions will take hospitals far beyond their traditional roles and into comprehensive community screening and delivery of services. The homebound and severely impaired elderly make up the group that private practitioners and group practices find most difficult to care for because of the attendant social needs, logistic difficulties, and low financial reimbursement. Hospitals and their affiliated community clinics are best equipped to care for such patients, coordinating the complex services and providing round-the-clock social and medical support. At present, not even the structure of prepaid health-maintenance organizations creates strong incentives to prevent nursing-home institutionalization, since, like most other health insurers, health-maintenance organizations do not cover long-term nursing-home care. The costs of such care fall to the individual members and are therefore outside the utilization strategies of the health-maintenance-organization plan. Strategies for a truly comprehensive "social health maintenance organization" are only now being proposed.[19] The first steps toward provision of total care for the homebound elderly are being taken in experimental federal programs, such as the one at St. Vincent's Hospital in New York City.[20]

A further stimulus for hospitals to move into long-term care is the projection that this will be the greatest growth area in health care over the coming decades.[21] The budgets of nursing homes are projected to reach $76 billion within this decade.[22] New explorations in federalizing Medicaid and shifting Medicare resources toward long-term care are perhaps clues that future control of total federal allocations for health care may be gained primarily at the expense of the acute care sector.[23] If hospitals remain devoted solely to acute care and if the pressures to reduce use persist, these hospitals may soon be delivering extraordinarily expensive care to a very small fraction of the populace. Moreover, if they do not begin to move into long-term care, acute-care hospitals may find themselves at the mercy of the growing and tightly organized for-profit nursing-home chains.

The resources, power, research skill, and versatility of acute-care hospitals are crucially needed by the growing and changing long-term-care system. The greatest resistance to hospitals' moving in this direction comes from health-care planners who fear that hospitals will "medicalize" the long-term-care system, bringing expensive, high-technology procedures into what should remain a low-technology system of care. That view may well reflect a problem in the identity of hospitals, which have become so wedded to technologic interventions that they have difficulty recognizing long-term-care as an important and valued challenge. The demographic and economic realities described in this paper may force a form of identity crisis on acute-care hospitals. That process could be painful, but it could also put hospitals in closer touch with their own historical mission of supporting and caring for the elderly and chronically ill.

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MEDICAL INTELLIGENCE

CURRENT CONCEPTS

Chemotherapy in Head and Neck Cancer

WAUN KI HONG, M.D., AND RICHARD BROMER, M.D.

SQUAMOUS-CELL carcinoma of the head and neck accounts for five per cent of the cases of cancer in the United States. Only one third of patients with this neoplasm present with localized disease easily curable by surgery and radiation. These treatment methods, however, have not provided adequate tumor control in the majority of patients who present with advanced local and regional disease. Local recurrences occur in up to 60 per cent of these patients, and distant metastases develop in 20 to 30 per cent; survival remains poor (0 to 40 per cent).[1,2] Until recently, chemotherapy has been reserved only for those with advanced or recurrent stages of disease. Extensive prior therapy and declining performance and nutritional status of these patients has predictably led to poor responses. The search for new chemotherapeutic agents through Phase I and II studies and the development of effective drug combinations with minimal toxicity are the main avenue of current investigation. The value of induction chemotherapy before definitive local treatment is being intensively evaluated. This paper will review the role of chemotherapy in the care of patients with head and neck cancer.

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Patients with relapse at the primary site, in regional nodes, or in distant sites despite initial treatment with curative intent are considered to be candidates for palliative therapy. The prognosis for those with locally recurrent or disseminated head and neck squamous-cell cancer is dismal. The survival period is usually less than six months, despite the fact that systemic chemotherapy can induce objective tumor regression. Nevertheless, a number of chemotherapeutic agents, used either alone or in combination, have been evaluated.[3-5]

Single-Agent Chemotherapy

The systemic administration of single agents has produced a wide range of response rates that is due to variability in patient selection, response criteria, and methods of data collection. Nevertheless, three drugs have consistently been shown to have antitumor activity: methotrexate, bleomycin, and cisplatin (Table 1).

Methotrexate

Methotrexate has undergone the most investigation and is regarded as the standard therapy for recurrent head and neck squamous cancer.[3-5] Its dosage, schedule, and method of delivery have been extensively studied. The results of widespread experience with low-dose methotrexate (40 to 60 mg per square meter of body-surface area per week, given intravenously) have been published. Weekly administration appears to be consistently more effective than either monthly

Table 1. Drugs with Activity in Head and Neck Cancer (Adapted from Wittes[6]).

Drug	Evaluable Cases	Response Rate (%)
Methotrexate (weekly or twice a week)	400	30
Methotrexate (monthly loading courses)	107	29
Cisplatin	108	33
Bleomycin	298	18
Hydroxyurea	18	39
Cyclophosphamide	77	36
Vinblastine	35	29
Doxorubicin	34	24
Fluorouracil	118	15

Conversion of Existing Hospital Beds to Nursing Home Care Beds

QUESTION 9:

Have you decided to convert some existing hospital beds to nursing home beds? If so:

A) Where is this planned and will this process be restricted to surplus beds or would an entire hospital be converted?

B) Have any conversions begun?

C) What criteria are used in making these decisions? Are they a natural outcome of the Medical District Initiated Planning Process (MEDIPP) or are other factors brought to bear?

D) What will be done to accomodate patients currently eligible to receive care at hospitals which will convert all or some beds to nursing home beds?

If not:

A) Please elaborate on the past, present and future mission of a non-affiliated, rural, primary care hospital such as Alexandria, Louisiana.

ANSWER:

The conversion of existing hospital beds to nursing home care beds is under consideration as an appropriate strategy for several reasons. In districts where an excess of hospital beds and a need for nursing home beds is projected, the conversion of hospital beds to nursing home beds may be a viable alternative.

A) While the majority of conversions will probably involve surplus hospital beds, in a few districts it may be more appropriate to consider a change in the mission of an entire hospital from a primary medical and surgical hospital to an extended care facility. While total conversion is being studied as a possibility at some medical centers, the Department of Medicine and Surgery has not made any final decisions which would result in a mission change of this extent at this time.

B) Proposals for conversions are in the planning phase and are currently under review. Initial decisions concerning the proposals will be made by April 1983. In some cases final decisions are subject to congressional review in accord with Public Law 97-66.

C) The most basic criterion is the determination of the nature and extent of care required for veteran patients in the future. Various bed projection techniques and professional judgment are utilized to make informed estimates concerning future needs for hospital and nursing home beds. Where projections indicate that fewer hospital beds and more nursing beds are needed within a District, opportunities for conversion are considered.

Other criteria include: (1) the resources of other VA facilities and their capability for absorbing the hospital workload and for providing for the acute care needs of patients in VA nursing homes; (2) opportunities for conversion that will increase the quality of care provided; and (3) opportunities to increase the cost effectiveness of operations through conversion.

D) Most facilities which would convert beds would retain a primary medical capacity. Conversion of beds in a hospital from acute to long-term care would occur in those instances where there is little need for the acute beds, but there is a need for long-term care beds. Acute care will be provided in the nearest VA medical center that retains acute care capability. However, as noted above, no conversion will be approved without careful consideration of the capability of other VA medical facilities to absorb, if necessary, hospital workloads at the affected facility.

STATEMENT OF STANLEY N. ZWAIK, NATIONAL COMMANDER, JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Mr. Chairman and Members of the Subcommittee:

It is a privilege for me to appear here today on behalf of the Jewish War Veterans of the U.S.A. to discuss our views on the V.A.'s medical construction program.

At the outset, Mr. Chairman, I would like to thank you and the staff of this subcommittee for your hard work and dedication to the well-being of our nation's veterans. The membership of JWV, the oldest active war veterans' organization in the U.S.A., stands ready to assist you at any time to ensure that essential medical care and construction programs are maintained and fully funded, and that the health care needs of America's veterans are met.

We feel that our nation has a clear responsibility to ensure that quality medical treatment is available through the V.A. medical care system to meet these health care needs. However, we are concerned that our ability to meet this responsibility may well be threatened over the next two decades. The changing nature of medical practice, the present status of the V.A.'s medical care facilities, and the projected demographic changes in the veteran population and in that population's demand for health care are all factors in this regard.

The facilities of the V.A.'s health care system are deteriorating and becoming increasingly outmoded. Hospitals that were built before World War II are still in use. So are some buildings that were constructed at or before the turn of the century. Many of the structures presently in use in the system were built over thirty years ago. Since that time, major changes have been made in medical science and technology and in our standards of care. Many of these older hospitals simply do not have the space or configuration to use modern equipment, to meet modern standards of care, or to handle today's demand for medical care-- let alone that of the future.

In addition, the number of veterans who are 65 or older will rapidly increase over the next two decades-- and, as these veterans will need more health care and need it more frequently, the overall demand for V.A. health care services will increase as well. The V.A. projects that even if the percentage of veterans aged 65 or older who use their health care services annually remains constant, the actual number of these older veterans will triple from 798,000 in 1981 to 2.2 million in the year 2000. The V.A. health care system will thus soon face a substantial increase in demand for its services-- and this demand will not only be for geriatric and extended care, but for acute inpatient care to handle the increase in major illnesses which accompany advancing years. Given all this, we fear that if treatment capabilities and facilities of the V.A. medical care system are not expanded and upgraded soon in order to meet the needs of the next two decades, the V.A. will soon be unable to provide America's veterans with the health care they need and deserve.

JWV feels that the V.A.'s medical care and medical construction budgets must be given top priority and prime consideration over the next two decades. While the VA has never been expected to care for all veterans, and we do not ask for any change, we do ask that the VA continue the mandate under which it has operated these many years. It must plan for the health needs of the service-connected, disabled and needy veterans who are growing older. A constant and substantial investment in the capital plant of this system must be made now if our nation is to meet its minimum responsibilities to these veterans. We must ensure that adequate funds are made available annually to construct new medical care facilities and to renovate existing ones if we are to have an adequate V.A. health care system.

On this basis, Mr. Chairman, JWV applauds the substantial expansion in the V.A. medical construction budget that the President has proposed for FY 1984.

We believe that this increase offers the promise that the Administration--not just the Congressional Veterans' Affairs Committees and the V.A.--recognizes the importance of the V.A. medical care system and the urgency of the need for new construction and substantial renovation of its facilities. We hope that this is the first year of a series of increased and accelerated investments into the V.A. medical care plant.

We are pleased to see that this budget proposal contains funding for the long-delayed, and long-needed, replacement hospital at Minneapolis, for substantial modernization at the V.A.'s Biloxi and Gulfport, Mississippi facilities, and for numerous outpatient, clinical and general improvements at hospitals and facilities throughout the system. We are particularly supportive of this budget's substantial increase in funding over last year's levels for construction of new nursing home care units and for conversion of existing V.A. facilities to nursing home care units. This increase will add approximately 840 additional nursing home beds to an extended care program for which waiting lists already exist. If sufficient funds continue to be provided for new construction and conversions in this area, and if consistent increases in bed levels for this type of care are achieved over the next few years, we are gratified that the V.A. will be well on its way towards meeting its stated goal of 13,107 operating nursing home care beds in the V.A. system by 1987.

We are, however, concerned over the apparent lack of funds in the FY '84 budget proposals for construction of new domiciliary facilities or remodeling or renovating existing ones. This would mark the third fiscal year in a row in which no funds were provided for new construction in this area. We believe that substantial improvement of the V.A.'s domiciliary system is needed. Most of the V.A.'s domiciliaries are over fifty years old. Many domicilaries do not meet current standards of fire safety, and still maintain simple barracks-type wards with ..sufficient privacy and communal

toilet facilities. We believe that the number of aging veterans, particularly those with insufficient social or family resources to meet minimal care needs, will increase in the next twenty years. We urge this Subcommittee to closely monitor the needs of veterans for this type of care, and we urge you to consider providing additional funds in this area of the medical construction budget now.

Otherwise, we are generally satisfied with the V.A.'s current Five Year Medical Facility Construction Plan, covering Fiscal Years 1983 through 1987. We consider this plan to be a fair and reasonable attempt to establish priorities for construction and modernization throughout the V.A. system and to suggest V.A. medical construction budget needs in each fiscal year. There are some deficiencies. We feel that this Plan does not adequately address the present and future medical care needs of veterans in the State of Florida and in the city of Baltimore, Maryland. A recent V.A. study entitled "A Thirty Year Study of the Needs of Veterans in Florida" projects a need in 1990 for 1,019 more inpatient beds and 922 more nursing home beds than were active in FY 1981. According to our information, neither construction in Florida since that date nor future construction, as called for in the Plan, will be sufficient to meet the entire projected increase for these beds. We are concerned that present and future construction budget proposals based on this Plan may not take these needs into account. In addition, we note that this Plan considers the Baltimore VA Medical Center to be one of the ten medical centers most in the need of construction, replacement or major modernization in the V.A. system. As you know, significant plans for the construction of a replacement hospital in Baltimore were underway, and construction funds were actually appropriated, before this Administration cancelled this project in 1981. Despite this existing groundwork, no timetable has been set for the inclusion of funds in this or future years' budgets either for continued planning or construction of necessary facilities in the Baltimore area.

We urge you to take the needs of these areas of the country into account when considering the V.A. medical construction budget in this and future years.

Mr. Chairman, thank you for giving us the opportunity to express our views on these important matters.

PARALYZED VETERANS OF AMERICA

CHARTERED BY THE CONGRESS OF THE UNITED STATES

STATEMENT OF

FRANK R. DE GEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE

THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE VETERANS ADMINISTRATION MEDICAL CONSTRUCTION PROGRAM

MARCH 16, 1983

Mr. Chairman and Members of the Subcommittee, Paralyzed Veterans of America appreciates this opportunity to express its views on the Veterans Administration's medical construction program. PVA's members are all veterans who have experienced spinal cord injury or dysfunction. These veterans have considerable contact with the VA health-care system and the facilities in which the VA extends medical and health-care services.

PVA's statement will concentrate on two areas: first, it will examine the VA's construction plans, generally. Second, it will look into the specific needs of spinal cord injured veterans and examine some possible VA construction projects which would help ensure more adequate care for spinal

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cord injured (SCI) veterans. This latter part will occupy most of this testimony because PVA, as the only veterans' service organization dedicated to representing spinal cord injured veterans, considers it necessary that this Subcommittee be informed of the needs of SCI veterans. As will be discussed in depth later, the construction projects identified in this testimony are urgently needed.

It is worth noting that some of PVA's comments dedicated to the VA construction program are intended to actually save the government money. Under existing circumstances, the VA must provide SCI veterans with care which is actually more expensive and less appropriate than what is needed by such veterans. These cost-saving measures are aimed at providing SCI veterans with appropriate and timely care, which is PVA's foremost goal; however, this care can sometimes be done in a less expensive manner than is now being utilized.

Before examining the construction needs of the VA's Spinal Cord Injury Service, PVA would like to address a few points of serious but general concern. First, we remain very concerned that over a year ago the VA implemented a revalidation study but no official results of this study have been made available. This study was intended to examine the demographics of the veteran population in an effort to ensure that the types of care which veterans require are provided. Furthermore, the study was to result in the accurate geographic placement of VA health and medical facilities so that they would optimally meet the needs of veterans and at the same time prevent the wasteful expenditures for the construction of unnecessary VA facilities.

When the revalidation study (and the corresponding freeze on VA medical construction projects pending review) was announced, PVA offered its qualified support. We agreed that accurate placement of facilities was one of our major concerns. However, we insisted that the freeze on construction planning must not be just a guise for cutting expenditures that are to be made on behalf of the nation's veterans. In the absence of a final study, PVA questions the validity of spending VA funds in the conducting of these studies. Furthermore, if no true revalidation was conducted, this exercise must be regarded as only an expensive delaying tactic, whereby expenditures for medical construction projects have been delayed while construction costs have risen.

PVA is also concerned over a statement which appears in the most recent VA Five-Year Construction Plan, that for Fiscal Years 1983-1987. In that plan is a discussion of the VA's new Medical District Initiated Program Planning (MEDIPP), a procedure which is likely to improve the VA's medical facility construction planning process. However, at page iv of the Five-Year Plan there appears the statement that "it is anticipated that the MEDIPP process will provide for revalidation of project needs on an annual basis by directly relating construction requirements to the delivery of services." PVA believes that it fully understands the processes to be used in MEDIPP, but we fail to distinguish how the results of this yearly review will differ significantly from the present one. Under the existing system, the Department of Medicine and Surgery repeatedly recommends the construction of needed projects, but these needs-based recommendations are often ignored. PVA trusts that the annual revalidation under MEDIPP will not prove to be as disruptive as has the most recently implemented revalidation effort, which

was discussed above. In short, the new planning process must not become a bureaucratic maze nor a stalling mechanism, and revalidations must not be allowed to further complicate nor hinder the VA's construction process.

A second area which PVA would like to address is the current efforts by Congress and the Administration to expand employment opportunities by having unemployed Americans work on federal projects. There is a growing concern in Congress and the Administration over the plight of the unemployed citizens of this country, a concern which PVA shares. And, there is also serious consideration being given to stabilizing many of our decaying structures such as highways, bridges, and mass transit systems. PVA, again, agrees that some of our nation's most important and prized accomplishments must not be allowed to deteriorate further.

VA health-care facilities, like the interstate highway system, are part of the nation's assets and both were designed to contribute to the national defense. The interstate highway system was intended to allow rapid mobilization in times of national emergencies; VA hospitals were meant to care for the men and women who have answered the nation's call to service during times of crises.

It would not be inconsistent with the aims of a restoration/employment measure to include VA facilities as objects for repair, and it would be giving needed attention to the urgent situation which surrounds many VA facilities. Too many such structures are being allowed to deteriorate even though their assigned purpose is to care for the increasing number of veterans who stand in need of health and medical services.

The Brockton, Massachusetts, VA Medical Center is an example of the decay which PVA has observed within the VA health-care system: the situation at Brockton has existed for a number of years and continues to worsen. Quite briefly, the Spinal Cord Injury Center there is in urgent need of renovation. And, it is filled to capacity while other SCI veterans await admission. Yet, in the face of these facts the Veterans Administration speaks of reducing SCI beds in that facility, largely because of the facility's poor condition and the major renovations which would be required to make the SCI facility truly operative.

Admittedly, the Brockton VAMC's Spinal Cord Injury Center is a particularized example of the type of decay which PVA has seen occur within the VA's medical and health-care facilities. But, it represents one of the grandest, most innovative fields of care for which the VA is known, because the VA has led the nation in development of spinal cord injury care. Nonetheless, even that noble venture is being allowed to deteriorate due to economic difficulties and fiscal policies.

Numerous VA facilities need prompt attention, and many, such as Brockton, are located in geographic areas where capable workers are unemployed. At a time when the nation seeks to restore national assets, to revive the productivity of its workers, and to strengthen the national defense, it is only reasonable that VA medical and health-care facilities be provided for in any restoration/employment measure created by this Congress. PVA would support any reasonable measure which included this provision.

In addition to these restoration projects, PVA has heard the Director of the Office of Management and Budget state that the Administration may seek to accelerate the construction of new VA medical facilities that are needed and which are provided for in future years' budget projections. PVA assumes that this, too, is a measure aimed at increasing employment opportunities and at meeting the VA's needs in a more timely manner.

PVA supports the acceleration of new construction projects which have already been identified as required by the Veterans Administration. Later in this paper is a discussion of one such project, a long-term SCI care facility at the Hines VA Hospital in Hines, Illinois: PVA feels that this project clearly should be considered if there is a program of accelerated construction. As will be seen later, in the longer discussion of the situation which exists at Hines, the VA's medical experts have long agreed with PVA that construction must begin soon if the needs of SCI veterans in that geographic area are to be met.

Mr. Chairman and Members of the Subcommittee, PVA trusts that you will work actively to have the renovation and construction of VA medical and health-care facilities included as part of the federal infrastructure which is to receive needed attention. Above are but two examples of VA facilities which stand in need of such consideration, and one would benefit from restoration and the other from accelerating the VA's construction program. Now is the time for Congress and the Administration to act, it appears to PVA, if the Veterans Administration's Department of Medicine and Surgery is to remain a viable provider of services to the nation's veterans.

Whether there is a sudden change in the construction process, or whether the VA continues as it has in the past, there are certain requirements of the VA's Spinal Cord Injury Service which must be addressed. These particularized requirements too often have been ignored in the past. However, there is now available new information upon which the VA can accurately plan the construction of SCI acute- and long-term care projects.

This newly-acquired data will be explained in some detail in the following pages, and the remainder of this testimony is dedicated to examining the needs of the SCI Service. The methodology used by the VA and PVA in gathering this information was very similar to that which was to be used in the revalidation studies to locate the appropriate sites for placement of VA health and medical facilities.

The examination of the requirements of the VA's SCI Service is presented in four parts: Part I will summarize the demographics of SCI veterans and how the needs of this group of veterans are different from those of veterans in general. Part II will discuss briefly, based on these demographics, the need for constructing new acute-care SCI Centers in the Southwest. The SCI bed shortage in Texas, for example, has already reached alarming levels.

Part III will explain the need for long-term care SCI facilities, and noted specifically is the absence of suitable facilities in Tampa, Florida, Houston, Texas, and Hines, Illinois. Finally, Part IV will offer suggested supplements to VA construction projects, as the VA seeks to care for the needs of SCI veterans who reside in thinly settled regions of the nation where the construction of SCI Centers is not economically feasible.

Admittedly, this testimony goes into some depth in its analysis of the construction requirements of the VA health-care system, as that system serves SCI veterans. However, SCI veterans are some of the most severely disabled persons who have rendered service to the nation; therefore, PVA strongly believes that an in-depth examination of their needs should be made at this time.

Part I. Demographics of SCI Veterans and of the VA Health-Care System

The Spinal Cord Injury Service that was created in 1954 had 11 Spinal Cord Injury Centers in VA medical centers throughout the nation. Since then, the SCI Service has expanded to only 19 Centers, the most recently constructed Center opening in January of 1981 at the Augusta VA Medical Center in Georgia.

In an effort to continue the VA's advancements in SCI care, PVA's Research Program has been working with Dr. Juan Fonseca, VA Director of SCI Service. One of our mutual projects has been the development of current information on the SCI veteran population. PVA feels that this is a quite comprehensive study of SCI veterans. It should meet the methodology requirements which the Veterans Administration has established for analysis of veterans as users of VA medical and health-care facilities and services. Therefore, it would appear that progress could be made at this time toward meeting many of the construction requirements of the Spinal Cord Injury Service.

Any demographic study of people generally begins by showing where they are located geographically: one finding which distinguishes SCI veterans from the general veteran population is the distribution of these identifiable veterans. The top ten states of residence of SCI veterans, compared with that of the general veteran population, are listed below:

Veterans' Top Ten States of Residence

SCI RESPONDENTS		GENERAL VETERANS POPULATION	
California	10.0%	California	11.2%
Florida	6.8%	New York	8.1%
Texas	5.9%	Pennsylvania	5.8%
New York	5.6%	Texas	5.5%
Pennsylvania	4.9%	Illinois	5.1%
Ohio	4.9%	Ohio	4.9%
Michigan	3.2%	Florida	4.5%
Illinois	3.0%	Michigan	3.9%
Massachusetts	3.0%	New Jersey	3.7%
Wisconsin	2.6%	Massachusetts	2.9%

More accessible buildings and warmer weather have caused many spinal cord injured veterans, in proportions which exceed the general veteran population, to move to the "Sunbelt States." These States also seem to offer desirable transportation, employment, and recreation facilities These factors cause PVA to believe that this geographic area will continue to see in-migration of SCI veterans.

The VA, at this time, is showing an unprecedented interest in the accurate placement of its health-care facilities. Therefore, as the VA considers appropriate locations for SCI veterans, special consideration must be given to these settlement patterns, and the VA should not rely on general veterans population statistics in making such decisions.

In understanding the importance of this demographic information and that which will follow, it would be helpful to review a map of the United States on which the location of VA SCI Centers is noted:

Location of VA SCI Centers

In addition to these SCI Centers, there is an SCI Service-approved out-patient clinic at Sepulveda, California.

Furthermore, there are two out-patient clinics which care for SCI patients but which are not officially part of the SCI Service. They are located in Phoenix, Arizona, and Indianapolis, Indiana. These two clinics are headed by nurse practitioners who have been trained in the special needs of SCI patients.

All three SCI out-patient clinics have proven to be very effective and beneficial: they have helped reduce the load being placed on SCI Centers, or they are filling the void where there are numerous SCI veterans but there is no convenient SCI Center to care for their needs.

These nineteen SCI Centers are hard-working facilities dedicated to serving SCI veterans, as the following distribution of discharges of in-patients reveals:

Distribution of In-Patient Discharges of SCI Veterans
From the VA's SCI Centers and from All VA Medical Centers
Fiscal Year 1976-Fiscal Year 1982

		BEDS	N	%	%'
1.	Memphis	160	5109	13.93	7.37
2.	Long Beach	197	4528	12.34	6.54
3.	West Roxbury	100	4105	11.19	5.93
4.	Richmond	145	3891	10.61	5.62
5.	Wood	56	2732	7.45	3.94
6.	Tampa	42	2101	5.73	3.03
7.	Palo Alto	30	2074	5.66	2.99
8.	Hines	135	1816	4.95	2.62
9.	Castle Point	58	1509	4.11	2.18
10.	Miami	37	1386	3.78	2.00
11.	Houston	22	1343	3.66	1.94
12.	Cleveland	60	1329	3.62	1.92
13.	St. Louis	32	995	2.71	1.44
14.	San Juan	20	875	2.39	1.26
15.	Bronx	80	790	2.15	1.14
16.	Hampton	22	639	1.74	.92
17.	East Orange	36	623	1.70	.90
18.	Brockton	58	435	1.19	.63
19.	Augusta	60	395	1.08	.57
	Totals	1350	36,675	100.00	52.94

N - Number of Discharges

% - Percentage of Discharges from SCI Centers

%' - Percentage of Discharges from all VAMC's, which means that nearly half (47.06 percent) of all SCI discharges were made by non-SCI facilities.

It is not necessary in a testimony of this nature and short length to list all 152 non-SCI facilities within the VA and the number of discharges they made over a significant period of time. However, thirty such facilities made over 400 discharges each between Fiscal Year 1976 and Fiscal Year 1981:

Discharges of SCI Veterans from VA Non-SCI Facilities
Fiscal Year 1976-Fiscal Year 1982

1.	Dallas	774
2.	Portland	735
3.	Minneapolis	683
4.	Ann Arbor	679
5.	San Antonio	637
6.	Seattle	612
7.	Little Rock	611
8.	Phoenix	603
9.	Birmingham	588
10.	Charleston	560
11.	Durham	519
12.	Indianapolis	514
13.	Atlanta	513
14.	Oklahoma City	503
15.	Denver	499
16.	San Diego	496
17.	Columbia, SC	488
18.	Louisville	482
19.	Shreveport	476
20.	Jackson	471
21.	Temple	467
22.	Lexington	453
23.	Pittsburgh (Aspinwall)	451
24.	New Orleans	428
25.	Gainesville	427
26.	Kansas City	426
27.	Nashville	424
28.	Albuquerque	416
29.	Cincinnati	412
30.	Allen Park	407

Nine other non-SCI facilities made at least 300 SCI discharges, each, during this same time period, and twenty-four such general facilities made at least 200 SCI discharges each. In all, there were 32,603 SCI in-patient discharges made by non-SCI facilities during these six years.

It is also meaningful to illustrate the number of SCI discharges by VA medical district and region, and the following table contains this useful information:

Discharges of SCI In-Patients by Medical Districts and Regions
Fiscal Year 1976-Fiscal Year 1981

Districts	Number Of Discharges			Regions		
	N	%			N	%
1	5,432	7.94	(Brockton, West Roxbury)	#1 -	10,464	15.10
2	1,029	1.49				
3	4,003	5.78	(Bronx, Castle Point, San Juan)			
4	1,378	1.99	(East Orange)	#2 -	9,392	14.28
5	952	1.37				
6	998	1.44				
7	5,097	7.36	(Hampton, Richmond)			
8	1,467	2.12				
9	2,196	3.17	(Augusta)	#3 -	16,630	24.00
10	1,713	2.47				
11	6,496	9.38	(Memphis)			
12	4,336	6.26	(Miami, Tampa)			
19	1,889	2.73				
13	2,115	3.11	(Cleveland)	#4 -	11,339	16.37
14	1,338	1.93				
15	756	1.09				
16	3,285	4.74	(Wood)			
17	2,187	3.16	(Hines)			
21	1,618	2.34	(St. Louis)			
18	1,083	1.56		#5 -	8,793	12.69
20	4,398	6.35	(Houston)			
22	922	1.33				
23	1,190	1.72				
24	1,200	1.73				
25	1,711	2.47		#6 -	12,160	17.55
26	5,589	8.07	(Long Beach)			
27	2,864	4.13	(Palo Alto)			
28	1,996	2.88				
TOTAL					69,278	

SCI Centers Are Noted In Parantheses

It is evident from the previously cited data that the VA Spinal Cord Injury Service is in need of expansion, a finding long recognized by the VA's Department of Medicine and Surgery.

The VA has prepared two comprehensive studies of SCI veterans and the demands they will make on the VA health-care system. These studies are entitled "The Spinal Cord Injury Program Plan: FY 1980—1987" and "Estimated Bed Requirements of the Spinal Cord Injured Veteran, 1985—1990." The first noted study is a broad analysis of the VA's SCI program (to include staffing needs, medical specialities required, and other appropriate health-care matters). At the very core of the study is the assumption that the VA would construct as many SCI Centers as are needed. And, the study assumes, Centers will be placed where needed in order to better serve veterans who experience spinal cord injuries.

It should be stressed that at the time of publication, in 1980, the VA had fewer SCI Centers than it does today but was able to extend care to non-veterans on a space-available basis. Today, most SCI Centers are unable to meet even the demands placed on them by SCI veterans.

In early 1980 the Veterans Administration had 1,365 SCI beds, which is about the same number as exists today, three years later. Even though Centers have been added to the SCI Service, the size of existing facilities has been reduced by closing entire SCI wards.

At the time of its studies, however, the VA estimated that by Fiscal Year 1985, 1,845 beds as a <u>minimum</u> would be needed in the SCI Program. The VA

admitted that this figure was low and that it was based on an assumption that only 25 percent of all SCI veterans would require hospital services in any given year. It was based, also, upon the stated assumption that there would be no more wars.

It is difficult to ascertain from the data available on SCI veterans' demographics and their usage of the VA system what exactly is the frequency of use; however, the following statistics are helpful in understanding that there existed only 1,365 VA SCI beds when the data was gathered, but the VA system treated 16,279 individual SCI veterans between FY 1976 and FY 1981:

Frequency of In-Patient Discharges for SCI Veterans
from VAMC's
Fiscal Year 1976-Fiscal Year 1981

[illegible]	#	%
1	3,695	22.90
2	2,733	16.90
3	2,177	13.30
4	1,783	10.40
5	1,257	7.70
6	978	6.00
7	647	4.00
8	422	2.60
9	467	2.90
10	156	1.00
11	230	1.30
12	198	1.20
13	133	.81
14	109	.67
15	74	.45
16	69	.42
17	46	.29
18	28	.17
19	26	.16
20	15	.09
21	17	.10
22	6	.03
23	11	.07
24	2	.01
25	6	.03
26	6	.03
27	5	.03
28	1	.006
29	1	.01
30	1	.006
31	2	.01
32	1	.006
33	1	.006
34	2	.01
35	1	.006
36	1	.006
37	1	.006
38	1	.006
44	1	.006
	16,279	100.00

Accurate placement of new SCI facilities is as important as is the expansion of the system by the addition of more beds: the above-mentioned map, which shows the location of existing SCI Centers, and the cited discharges of SCI veterans from VA Medical Centers by districts and regions, combine to help show where new SCI Centers should be located.

Part II: New SCI Centers--Needed in Texas and the Southwest

The initial information from the SCI Study (the final study is not yet prepared) shows a definite need for increasing the number of SCI beds. There is, above all, a need for establishing additional Spinal Cord Injury Centers in the Southwest because of the great distances separating SCI veterans from existing Centers and because of the heavy usage already being placed on those Centers which surround this vast region.

Medical Region 6 includes two SCI Centers, but this Region covers an enormous area of land ranging from western Texas through California. Furthermore, the adjoining Medical Region 5 contains only one SCI Center, Houston, Texas. North of Houston there is not another SCI Center in the United States.

Palo Alto, California, and Houston serve this region: VA reports for the period ending May 31, 1982, show an occupancy rate of 93% for Palo Alto and 100% for Houston. These figures represent an average daily census of 28 patients for 30 beds in Palo Alto, with a total of 52 individual veterans hospitalized per month. At Houston, the average daily census for this period was 21 patients for 22 beds, and a total of 29 patients were hospitalized each month.

Quite succinctly, veterans residing in the Southwest must travel considerable distances for SCI care, only to arrive at VA Centers which are usually already filled to capacity.

i. Dallas

PVA's highest priority for the establishment of a new SCI Center is in Dallas, Texas. Demographics support establishing an SCI Center in Dallas. The Houston, Texas, SCI Center, while it may appear to be ample for the State of Texas, is not. The Houston facility's occupancy rate remains near 100 percent, according to VA reports and PVA's observations. VA reports for the period ending May 31, 1982, show that at Houston there was an average daily census of 21 patients for 22 beds, with one bed remaining in reserve for emergencies. In addition to this daily census of patients in the SCI Center, 8 other SCI veterans were hospitalized in non-SCI beds. In short, this 22-bed facility is treating on the average 29 veterans at a time.

Dallas has a general VA Medical Center, and as noted above in the table "Discharges of SCI Veterans from VA Non-SCI Facilities," this non-SCI facility treats more SCI patients than any other hospital in the VA system, and between 1976 and 1982 it treated more SCI veterans than did four of the 19 SCI Centers.

The addition of a 60-bed SCI Center in Dallas would meet only the needs of SCI veterans in that catchment area who are being treated in general hospitals: it would be a minimal (but vitally needed) addition to the SCI Service in that it would help take care of current requirements which are not being amply met. For it to address the continuing influx of SCI veterans to the Southwest, the facility would need considerably more than 60 beds.

ii. San Antonio

To further alleviate the critical bed shortage for spinal cord injured veterans in this area, PVA's second priority is the establishment of a Spinal Cord Injury Center in San Antonio, Texas. The ever increasing numbers of SCI veterans in Texas, the almost nonexistent availability of beds at the Houston SCI Center, and the size limitations which restrict the recommended expansion of the Dallas VAMC all necessitate the need for this center.

The location of San Antonio, while close to Houston and Dallas, is such that it can serve the growing area of South Texas. Additionally, the extremely strong and valuable relationship between the San Antonio VAMC and the University of Texas at San Antonio Health Sciences Center represents the type of affiliation which most adequately meets the needs of veterans.

The San Antonio VAMC currently has an existing structure that could quickly and at a relative small cost be converted into a spinal cord injury center. The utilization of station funding could accelerate the creation of a center at this facility with no significant effect on the VA's construction budget. Additionally, PVA, in visits to the San Antonio VAMC, has found the staff willing and enthusiastic in developing a spinal cord injury center.

Due to the space limitations at the Dallas VAMC that restrict the number of possible SCI beds for that facility, San Antonio is a needed corollary if the needs of SCI veterans are to be met. This center would serve a catchment area extending to the Mexican border. Presently, SCI veterans living in El Paso, Texas, must go to Long Beach, California, for care.

iii. The Southwest

PVA's third priority for the establishment of an SCI Center is in the Southwestern United States. There are several potential sites for this suggested center. The VA SCI Service and PVA consider, in the selection of a site in the Southwest (or of any other site such as has been recommended in Texas) the following five factors: availability of existing, suitable structures and land; proficiency of medical staff in disciplines critical to spinal cord injury care; strong affiliation with a medical school; readily accessible in terms of geography; and, adequate transportation systems in the area.

In a continuing review of the needs of spinal cord injured veterans, PVA has investigated potential sites for SCI Centers in the Southwest. Furthermore, to facilitate our efforts, PVA has created a Spinal Cord Injury Care Committee whose mandate is to monitor and review the Veterans Administration's Spinal Cord Injury program. This Committee is to address both distinct local problems and the broader regional and national issues regarding spinal cord injury care. As this Committee develops information on the needs of SCI veterans, its recommendations and observations will be brought to the attention of Congress and the Veterans Administration.

The sites that PVA has examined as potential SCI Center locations are Salt Lake City, Utah; Denver, Colorado; Phoenix, Arizona; and Albuquerque, New Mexico. Each of these meet some or all of the criteria that the VA and PVA feel to be essential in the establishment of Spinal Cord Injury Centers. Furthermore, each one would provide increasingly important future services

that are required because of the in-migration of SCI veterans to the Southwest.

The Salt Lake City VAMC has an excellent staff and medical school affiliation. The Denver VAMC is located near the Craig Rehabilitation Hospital, which houses a non-VA SCI Center. This co-location would enable the VA to extend and to receive information beneficial to all spinal cord injured Americans.

At Phoenix, there is already an unofficial VA SCI clinic (one not part of the VA's SCI Service). Furthermore, the Phoenix area has one of the heaviest concentrations of SCI veterans in the Southwest.

Replacement of the Albuquerque VAMC is one of the VA's highest priorities, as contained in the most recent "Five Year Medical Facility Construction Plan." There are approximately 181,800 veterans in the Albuquerque service area, and it is located in a VA Medical District (25) that has approximately 718,000 veterans. Quite importantly to SCI veterans, the Albuquerque VAMC has a close affiliation with an excellent medical school, which is located only a short distance away. Furthermore, there are on the campus uncommitted grounds where a long-term SCI facility could be established in the future. (Co-location of long-term SCI facilities with SCI Centers is of paramount importance.) The VA should give serious consideration to inclusion of an SCI Center in the proposed replacement and modernization project at Albuquerque.

Part III: Geriatrics and the Demographics of SCI Veterans:Long-term Care SCI Facilities Are Needed at Houston, Tampa and Hines

There are a number of significant findings in the VA-PVA demographic study of SCI veterans which should be highlighted in any discussion of the construction requirements of the VA's medical system. That is, special attention must be given to the exigencies of aging veterans. PVA has a special concern for the requirements of aging SCI veterans.

In its examination of the demographics of SCI veterans, PVA mailed questionnaries to 97,889 veterans. These individuals were chosen to participate in this study because they had been identified by the VA's Department of Veterans Benefits by their loss of function. They were chosen because of their having (or potentially having) spinal cord injuries.

Most respondents to the questionnaries served in World War II (51%) and are over 50 years of age (64%). Sixty-four percent (64%) of all the respondents are service-connected disabled veterans, while thirty-five percent are non-service-connected. Sixty-seven percent (67%) of those surveyed responded that they use VA facilities. It was not surprising that 97% of all respondents were men, but, like other groups, the largest group of responding women served in World War II.

These results do not differ greatly from those reported for the general veteran population. However, it should be kept in mind that the settlement pattern by states, as shown earlier, indicate that they do not necessarily

reside in the same states as do corresponding numbers/percentages of veterans, generally.

Total SCI Respondents

DISABILITY:		PERIOD OF SERVICE:	
PARAPLEGIC	- 36%	WORLD WAR I	- 1%
QUADRIPLEGIC	- 11%	WORLD WAR II	- 51%
POLIO	- 10%	KOREA	- 19%
MS	- 41%	VIETNAM	- 20%
		PEACE	- 6%
SEX:		COMPENSATION & PENSION:	
MALE	- 97%	SERVICE	- 64%
FEMALE	- 2.6%	NONSERVICE	- 35%
USE VA FACILITIES:		AGE:	
YES	- 67%	-30	- 3.3%
NO	- 32%	31-35	- 8.0%
		36-40	- 8.1%
		41-45	- 5.0%
		46-50	- 10.0%
		50 OVER	- 64.0%
		UNDER 50	- 35.0%

MARITAL STATUS:

SINGLE	- 12.0%
MARRIED	- 68.0%
WIDOWED	- 3.8%
SEPARATED	- 2.6%
DIVORCED	- 13.0%

PVA believes the special needs of the aging SCI veteran must be addressed in planning for VA health-care delivery in the future. In the "PVA Response to

Spinal Cord Injury Program Plan FY 1980-1987," dated March 15, 1980, PVA noted that the VA proposed to expand the SCI service nationwide from 18 centers with 1,386 beds at that time, to 23 locations with 1,565 beds.

On a level-of-care breakdown of the VA's proposal, this would provide 236 beds (15%) for intensive rehabilitation, 845 beds (54%) for sustaining care, and 484 beds (31%) for long-term care. PVA concurred with the VA that an increase in SCI beds was required and PVA has supported an increase in the percentage of long-term care beds from approximately 25 percent (the existing percentage) of total SCI beds to the projected level of 31 percent of total beds. It appears from existing data, however, that even the dedication of 31 percent of all VA SCI beds to long-term care may not prove to be adequate.

The request for improved and expanded care for aging veterans has been expressed by all veterans' service organizations, the Congress, members of the Administration, and our society in general. The questions of future funding of VA construction projects and the VA's ability to provide the best possible health-care services to aging veterans are closely related.

The present large number of older SCI veterans and the expected increase in the Sunbelt States requires prompt action by the VA to provide for their health-care needs. Aging spinal cord injured veterans are a relatively new medical phenomenon. Consequently, no serious attention has been given to their needs. However, it is important that on July 28, 1982, this Subcommittee conducted an oversight hearing on the needs of spinal cord injured veterans. At the conclusion of that hearing, the Honorable Ron

Mottl, then Chairman of the Subcommittee, asked the VA to begin a review of the special needs of aging SCI veterans.

Whenever SCI veterans who require long-term care are forced by bed shortages to occupy acute-care beds, a number of undesirable results occur. First, this is a waste of money, to keep persons in the most expensive beds continuously, when what they actually need is daily personal assistance and access to acute-care facilities when medical emergencies arise. This is the reason that PVA supports placing SCI Centers on the campuses of general VA Medical Centers, with long-term care SCI facilities then being attached to the SCI Centers.

Second, SCI veterans who do not require long-term care, and who do not require hospitalization, still require regularly scheduled medical checkups, to ensure that problems are diagnosed before they become critical and possibly life-threatening. When emergency situations develop, or when routine check-ups are needed, beds are too often already filled with less seriously ill SCI patients who would find long-term care actually to be more appropriate. The result is that these long-term care SCI patients must be moved out of the SCI unit to wards where the personnel are not experienced in dealing with the patients' medical needs.

Because of the bed shortage, emergency admissions mean, first, that long-term care patients must be moved about. Second, it means that SCI veterans who have examinations scheduled must be abruptly notified of cancellation and rescheduling. This can be especially frustrating for catastrophically disabled veterans who have unique travel problems that must be arranged in

advance. Furthermore, the problem is aggravated when SCI veterans must plan to travel long distances for care, as is often the case in the Sunbelt States.

i. Houston

The initial information from the SCI Study shows a definite need for increasing the number of SCI beds, and one clear example of where long-term care SIC beds are needed is the Houston, Texas, SCI Center. The use of the Houston SCI Center was documented earlier, under the examination of a need for an additional SCI Center to be established at Dallas, Texas. As noted, there is at Houston a 100% occupancy rate, and the next closest SCI Center, that at Palo Alto, California, has an occupancy rate of ninety-three (93%) percent.

The Houston, Texas, VAMC has one of the most overworked SCI Centers in the nation, and there is the demand there for the establishment of a long-term care SCI facility. This facility, should it be constructed, would accomplish two things: first, it would provide expanded services and facilities for certain SCI veterans and, second, it would remove some of the burden now being placed on the Houston SCI Center by veterans who could be amply cared for in less expensive but even more appropriate long-term care facilities.

ii. Tampa

The State of Florida is a good example of where the VA has worked to meet the health-care needs of SCI veterans but where no suitable attention has been given to the needs of aging SCI veterans. Florida is currently the second largest state in number of SCI veterans treated by the VA. (Only California has more SCI veterans than does Florida.)

There are currently two designated SCI Centers in the State, which are located at Tampa Veterans Administration Medical Center and Miami VAMC. Both of these are excellent Centers and provide in-patient and out-patient care. But, PVA is especially concerned about the present and future capability of the SCI Center at Tampa VAMC to fulfill its assigned mission. This unit has 42 beds and is currently overutilized, according to VA SCI Service information.

The Tampa SCI Center now works at or within 1 bed of 100 percent occupancy on a daily basis. The unit is overcrowded and has a continuous waiting list for patient admission.

About three years ago the VA began negotiations to acquire property adjacent to the Tampa VAMC campus, upon which there was to be constructed an SCI long-term care facility and parking spaces for both VA employees and patients and visitors at the medical center. For whatever reason, internal discussions and arguments prevailed in the VA, until the agency lost the option to acquire this valuable and needed land. Now, a consortium of physicians (at least one of whom is a former VA employee) has purchased the

land and is offering to sell it to the VA at approximately twice the amount that was sought by the original sellers. In short, the VA did not move in a timely manner to resolve the urgent need for long-term care SCI beds at the Tampa Center.

iii. Hines

Mr. Chairman and Members of the Subcommittee, PVA is aware of several VA medical facilities where the health and medical care and the well-being of spinal cord injured veterans are being sacrificed because of the conflicting goals held by the VA's Department of Medicine and Surgery and its Office of Construction. The most notable, and most urgent example, is Hines VA Hospital in Hines, Illinois.

On July 28, 1982, PVA testified before this Subcommittee, at which time we addressed the problems that exist at Hines because of the VA's failure to construct a long-term care facility for SCI veterans. Those problems should be repeated briefly at this time.

At Hines, there is a 160-bed acute care SCI Center, but there is no long-term care SCI facility. The VA's Department of Medicine and Surgery has long seen the need for a long-term SCI facility at Hines, and one was once listed in the VA's Five-Year Construction Plan. However, despite the Chief Medical Director's best efforts, no construction is expected in the near future. It is very significant that the most current Five-Year Plan does not include a long-term care SCI facility at Hines.

PVA, for eight years, has called for the construction of a long-term care SCI facility at Hines. And, the Chief Medical Director has consulted PVA for about three years concerning this project. He has agreed that the long-term care facility is needed, but the recent efforts have been dedicated to reaching a feasible alternative to the construction of the needed 40-bed

long-term care facility. The alternative is to bridge the gap which exists between urgent, current demands and the construction of a suitable facility. Despite this three-year effort, no lasting solution has been reached by the VA, largely because no alternative to specialized long-term care will meet the needs of SCI veterans.

The most recent solution proposed by the VA, as of the July 28, hearing, was to contract with nursing homes for the care of SCI veterans. It was decided by those in charge of the Hines facility that sixteen (16) SCI veterans in need of long-term care would be sent on a contract basis to non-VA nursing homes. Others would be placed in the Hines VA nursing home, and still others would be dispersed throughout the existing acute-care SCI facility. (In 1981 18 such veterans were sent by Hines to non-VA nursing homes, and at least 12 were placed in similar nursing homes during 1982.)

PVA recognized several problems inherent in the original Hines proposal: in the case of non-service-connected (NSC) disabled veterans, there is a statutory prohibition against contracting for more than six months, which means that the individual SCI veteran would be transferred to a nursing home, then back to the VA long enough to renew his eligibility for contracting care, and then out again to a nursing home. It is quite likely that by the time he is eligible to return to a non-VA nursing home, the original one will be filled and the veteran must then go to a different facility and be placed in the hands of personnel who are not familiar with him or with his SCI-related health-care problems.

Second, PVA remains fearful of non-specialized nursing home care for SCI veterans (whether VA or non-VA) because of the results we have witnessed. Too often, we have seen SCI veterans returned to SCI Centers for hospitalization after episodes in such homes.

Care of SCI patients in general nursing homes as often as not ends in a worsening of the individual patient's condition for a number of reasons, and this deterioration creates a need for expensive medical treatment and causes needless suffering for the veteran.

General nursing home personnel are not trained to deal with SCI patients, and a noteworthy example of this is the incidence of decubitus ulcers, a life-threatening condition for SCI patients. Only experienced personnel can treat such patients without doing considerable harm to them, since their circulation is greatly restricted and decubitus ulcers commonly arise from bed sores, burises, and pressure sores. Non-specialized nursing homes do not have qualified, experienced personnel, and they are therefore unable to care adequately for the needs of SCI veterans.

PVA was told originally that SCI veterans at Hines would be sent only to "accessible" nursing homes, which is of little comfort to us. Having a building with accessible bathrooms, for example, is not a substitute for having a facility whose personnel are trained to deal with SCI patients. Furthermore, there is no substitute for the concern and patience possessed by those who have chosen to make careers of dealing with spinal cord injured persons: nursing home personnel too often lack this willingness to work

daily with persons whose conditions are as demanding as are those of SCI patients.

This Subcommittee, on December 14, 1982, conducted a hearing dedicated to examining the VA's construction plans, projects, and efforts. PVA testified at that hearing and announced that because of this Subcommittee's earlier efforts in July, a satisfactory interim solution had been reached with the VA whereby some SCI veterans would receive appropriate long-term care at Hines.

The acceptable interim solution, which arose after the July 28, hearing, and which was reported to this Subcommittee on December 14, 1982, contained the following essential elements:

- The healthiest SCI patients in the SCI unit were to be moved into the VA's new general nursing home facility;

- SCI patients who were currently medically unstable, but who were in need of long-term care, were to remain in the acute-care SCI facility until their conditions improved, at which time they were to be transferred to the nearby VA nursing home;

- SCI patients in need of long-term care but who would continue to be medically unstable were to remain in the acute-care facility;

- Seven (7) SCI-trained FTEE were to have been assigned to the nursing home specifically to care for the SCI patients.

This interim solution was reached after a meeting on October 15, 1982, at which the Veterans Administration was represented by Dr. Earl Brown, Associate Deputy Chief Medical Director, and Mr. John R. Fears, Director of the Hines VA Hospital.

PVA is pleased to be able to report that the VA has kept its promises as to methods of caring for SCI veterans in the absence of a suitable long-term care SCI facility at Hines. Still, this interim solution leaves too many SCI veterans in the Chicago area without appropriate long-term care, because only a limited number can be cared for in the Hines VA general nursing home. Furthermore, needed acute-care SCI beds are continuing to be used for long-term care, which is an unduly expensive means of caring for these veterans. This arrangement ultimately creates a shortage of specialized beds for SCI veterans who need medical treatment.

Director Fears emphasized in a memorandum of October 18, 1982, that even with the interim solution, his facility "could not solve the overall problem for long-term care until a unit is constructed," and, he added, "Dr. Brown agreed after reviewing the problem that a long-term care unit is necessary."

Mr. Chairman and Members of the Subcommittee, as you know, long-term care is divided into five categories, with categories I and II being those veterans who require the most attention and assistance. SCI veterans normally are found in groups I and II. General nursing homes are able to care for only a very limited number of veterans who have this severe level of disability. Most nursing homes, in short, are able to attend to the needs of their occupants only if most are in category V, or those who are capable of

performing all or nearly all of their daily personal care tasks for themselves.

It is very important to note, Mr. Chairman, that in the absence of appropriate specialized facilities, the best-intentioned VA hospital managers find it doubly difficult to care for SCI patients. For example, VA general nursing home staffs do not desire, as a rule, to care for SCI veterans because of the added work and responsibility they entail. Quite typically, even when hospital directors mandate that SCI veterans be consolidated in contiguous areas so that they can be given specialized care, nursing home staffs use subterfuge to disperse the SCI veterans throughout the nursing home. This is done so that no one team of employees must provide the demanding services needed by the SCI veterans. The result is that SCI veterans are dispersed and thereby put into the hands of personnel who neither know how to care for them nor who want to expend the energy and time in learning the special needs of these veterans.

It is apparent that the situation at Hines flies in the face of both good management and of the VA's ability to care for severely disabled SCI veterans. The VA is unable to respond to this emergency situation either because Congress has made available restricted funding or because this and past Administrations refuse to spend monies for the care of needy veterans.

Considering that the VA has available over $1 billion in unobligated construction funds, PVA fails to understand why the VA has failed to approve construction of the 40-bed long-term care SCI facility at Hines. Our

puzzlement exists especially since health-care experts within the VA repeatedly have recognized the need for this project.

The VA's Five-Year Construction Plan is a needs assessment, not a construction plan or a funding vehicle. Nonetheless, PVA finds it very disturbing that the Hines SCI long-term care facility is not included in this plan. We are especially troubled by this omission since the VA's Department of Medicine and Surgery continues to express agreement with PVA that this construction project is urgently needed. It is also troublesome that the VA's Fiscal Year 1984 Budget request does not include a funding request for this project at Hines.

As noted earlier, PVA trusts that the construction of urgently needed VA health-care and medical facilities will be accelerated. We think that this would be very appropriate because it is a means of increasing employment opportunities and of restoring the federal infrastructure. No VA facility should be given a higher priority during this possible acceleration, or during the normal construction planning process, than the SCI long-term care facility at Hines VA Hospital.

Part IV: Cost-Saving Supplements to Construction Aimed at Caring for SCI Veterans

PVA believes, based upon our on-going observations, that SCI veterans can sometimes have their health-care needs met through improved VA services which would be more cost-effective than are certain aspects of the presently-employed means of caring for them. We will briefly outline some of these services below, recognizing that should Congress have an interest in taking them to fruition there likely will be need for in-depth examination. It seems appropriate to discuss these non-construction methods of caring for the needs of SCI veterans because of the tumultuous and uncertain environment in which VA decisions are made concerning the construction of health-care facilities.

PVA does not support alternatives to VA construction, since we adamantly believe that the best method of caring for SCI veterans is in appropriate VA facilities. However, where VA facilities cannot be built because of an inadequate population of veterans to warrant the construction of them, there are means available for providing adequately for SCI veterans' routine medical and health conditions. These sources of care would be adequate for SCI veterans so long as they have access to VA SCI Centers for care whenever serious conditions arise.

First, PVA urges that consideration be given to the establishment of additional satellite clinics for out-patient treatment. This recommendation is based upon the earlier-mentioned three such clinics that already exist within the VA. These clinics have proven themselves capable of meeting many

needs of SCI veterans in a timely and inexpensive manner. Furthermore, in thinly-settled areas of the nation, such clinics could save veterans (and the VA) travel costs. By means of these satellite clinics, SCI veterans would not have to undergo the rigors of lengthy travel in order to receive treatment for relatively minor SCI-related difficulties.

These satellite clinics possibly could be co-located with Department of Defense installations or stations, under VA-Department of Defense Sharing Agreements. Similar VA-DoD sharing agreements are to be implemented since passage of Public Law 97-174, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act." Congress clearly had arrangements in mind similar to these proposed by PVA, when it passed this legislation.

With improved sharing agreements, the use of DoD-supplied resources such as space, medical, diagnostic, or treatment equipment, maintenance, and transportation could be utilized by teams of VA health-care personnel who would examine and treat the patients. Combinations of physicians, registered nurses, rehabilitation therapists, and others could provide traveling teams to visit designated locations at specific intervals. PVA supports this concept and asks that the VA conduct further studies of its feasibility.

Second, PVA believes an expansion of the Hospital Based Home Care program would significantly improve the VA's capability of delivering high-quality care to aging SCI veterans. PVA has a number of members who have utilized this program to improve their quality of living. Every consideration should be given to placing more eligible veterans in this program.

Third, PVA supports extending the Fee Basis Home Health Care Program, because it is cost-effective and it allows catastrophically disabled veterans to maintain a viable home environment in their community. Where it has been used, the result is greater personal satisfaction for such veterans at less cost to the Veterans Administration.

Conclusion

Mr. Chairman and Members of the Subcommittee, PVA appreciates your time and consideration, as we have presented this testimony dedicated almost entirely to the construction needs of the VA Spinal Cord Injury Service. This Service is the provider of essential services to some of the nation's most disabled veterans; therefore, I am certain that the Members and staff personnel of this Committee understand why PVA has concentrated on construction requirements which are needed in order to better serve SCI veterans. Some of these requirements are urgent ones, and PVA trusts that this Subcommittee will act quickly to resolve shortages in SCI acute-care and long-term care beds.

As has been stated, PVA does have concerns for the entire VA health-care system and its construction needs. For example, we propose that the current revalidation study be completed as quickly as possible, so that the Veterans Administration can once again begin pursuing solutions to some of the problems which surround veterans health care. Furthermore, we hope that this Subcommittee and the VA will ensure that new revalidation proposals do not become cumbersome and thereby delay the construction or modification of VA medical facilities.

PVA has also requested that during consideration of possible employment measures in this Congress and by this Administration, emphasis will be placed on the VA's health and medical facilities as parts of the federal infrastructure which are to be renovated. Along these same lines, should there be an acceleration in the construction of needed VA health-care

facilities, PVA has offered a clear example of where a long-term care facility is needed at Hines VA Hospital, if the needs of SCI veterans are to be met. The situation at Hines is crucial.

Included in this statement has been a brief summary of preliminary demographic data on spinal cord injured veterans. We hope that the final tabulation of this material will be completed soon. In the absence of this final report, it is already evident that the demographics of SCI veterans do not parallel those of the general veteran population, and PVA has attempted to explain some of those variations. Based on existing data, which has been collected according to the VA's revalidation studies methodology, it is clear that SCI Centers must be constructed in Texas and the Southwest in order to care for the large number of veterans in those areas. Likewise, the demographic information shows that long-term care facilities are urgently needed in Houston, Texas, and Tampa, Florida, as well as at Hines, Illinois.

Finally, PVA mentioned briefly that there are cost-saving supplements that can meet some or most of the medical and health-care needs of SCI veterans who reside in thinly-settled regions of the country. These measures, such as the use of satellite clinics (perhaps as part of the VA-Department of Defense sharing agreements), expansion of the Hospital Based Home Care program, and extension of the Fee Basis Home Health Care Program, would be effective supplements to the VA's construction plans. They will meet the routine needs of SCI veterans so long as there are adequate acute-care and long-term care SCI facilities available to meet their more serious needs as they arise. These supplements to construction should receive serious consideration by

this Subcommittee if the VA's construction process continues to be as chaotic has it has been for the past few years.

Again, PVA appreciates the time and consideration extended to it by the Members of this Subcommittee and by the members of its cooperative and capable staff. We believe that the 98th Congress will be a productive, hard working one, and we are grateful that veterans have your concern and dedication.

Mr. Chairman and Members of the Subcommitee, this concludes my statement and I will be glad to answer any questions that I can.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DONALD H. SCHWAB, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

WITH RESPECT TO THE VETERANS ADMINISTRATION'S
MEDICAL CONSTRUCTION PROGRAM

WASHINGTON, D. C. MARCH 16, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab, and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

As you know, Mr. Chairman, when it was my privilege to testify before this Subcommittee last December in the waning days of the 97th Congress with respect to the Veterans Administration's five-year medical construction plan, we were all at a disadvantage since we had not yet been made privy to the results of the construction projects revalidation for the fiscal year 1984 and the out years as

directed by the former Administrator of Veterans Affairs on February 19, 1982 and, also, the President had not submitted his proposed fiscal year 1984 budget to Congress. With respect to revalidation, we had only been informally advised that the replacement hospital at Minneapolis, Minnesota had been revalidated, 34 other projects revalidated, 21 deferred, and one cancelled. We now have the revalidation report and the President's proposed budget for the Veterans Administration for fiscal year 1984 which would increase funds for major and minor construction by $195.5 million in outlays, for a total of $673.6 million.

Our primary concern with respect to construction is, of course, replacement hospitals, nursing home care units, domiciliaries and outpatient clinics. We are delighted that the budget contains $254 million for an 845 bed replacement hospital at Minneapolis, Minnesota and, also, $78.8 million for a major modernization project at the Biloxi, Mississippi medical center. However, we are deeply concerned that no anticipated date is given for construction of a VA replacement hospital in the Baltimore metropolitan area. You will recall that on May 11, 1976, President Ford announced that a 400 bed hospital would be built in Baltimore. Funds for planning and design were appropriated in the fiscal year 1977 and construction funds, in the fiscal year 1980. Construction was to have commenced between June and October 1980 with 1983 as the target date for completion. The Veterans Administration has already spent $8 million on this project, $3.5 million for working drawings and $4.5 million for purchase of the construction site. Then, the project was cancelled due to budgetary constraints according to the Veterans Administration. Notwithstanding, we are all aware that the local health planning agency which had authorized the overbuilding and overbedding of community hospitals for personal private financial gain strongly opposed the construction

of this badly needed replacement hospital. This is the same scenario that delayed construction and increased the cost of the VA hospitals in Portland, Oregon and Minneapolis, Minnesota. While the Baltimore facility is listed as number ten in the priority list of hospitals most in need of replacement or renovation, further delay will merely increase its cost. Further design plans are not necessary and since construction could start immediately, funding should be included in the fiscal year 1985 budget. In addition, Baltimore is a highly depressed area in the labor market and going forward with construction at that time would create a meaningful and needed jobs program.

Needless to say, we are also pleased that the budget includes funding for the construction of 60 bed nuring home care units at Loma Linda, California and Providence, Rhode Island, 120 bed units in San Francisco and West Los Angeles, California, Northport, New York and Miami, Florida. Also authorized is a 240 bed nursing home at Lyons, New Jersey which was originally scheduled to be one of 120 beds. However, under the revalidation process it was decided not to construct an additional 120 bed unit at East Orange, New Jersey, but to add 30 additional nursing home care beds by renovating an existing patient care building.

Mr. Chairman, we are concerned with the future of the Veterans Administration's domiciliary care program. As you know, the proposed fiscal year 1984 budget would reduce domiciliary care by $4.1 million, 334 operating beds and 110 FTEEs. In addition, the revalidation documents in my possession indicate that the proposed 208 bed domiciliary at Leavenworth, Kansas will be further reviewed in the upcoming fiscal year and, further, that the proposed combination 200 bed domiciliary and 60 bed nursing home care unit at Prescott, Arizona is to be changed. The reason given is that "the agency has since decided to proceed separately with a project for a 120 bed nursing care unit while studying the

best alternative for providing domiciliary care at the medical center." Present planning will reduce operating beds to 7,444 in 1984 and envisions a daily census of 6,700 veterans. The Medical District Initiated Program Planning (MEDIPP) anticipates a domiciliary requirement in the future for 7,900 veterans or 2.6 percent of the total veteran PATIENT population.

Mr. Chairman, the former Administrator alleged that the construction of VA health care facilities was predicated more upon the political ramifications thereof that providing facilities where most needed and his revalidation project was to develop a "defensible criteria," thus alluding that the criteria originally used was not defensible. The criteria used for construction sites is outlined in the five-year construction plan and will be enhanced and fine tuned by the Medical District Initiated Program Planning (MEDIPP) process which is a new strategic planning concept being developed by the Department of Medicine and Surgery and will play a major role in developing future five-year plans. Hopefully, Mr. Chairman, the increase in average employment of 2,306 personnel and the finessing of construction proiorities will bring needed relief to the sunbelt states without diminishing the quality and quantity of care throughout the rest of the nation.

This concludes my testimony, Mr. Chairman, and I will be happy to respond to any questions you may have.

BALTASAR CORRADA
RESIDENT COMMISSIONER, PUERTO RICO

RAUL TORRES-VIERA
ADMINISTRATIVE ASSISTANT

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STATEMENT OF HON. BALTASAR CORRADA

BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS

March 16, 1983

Mr. Chairman, members of the Committee, I appreciate the opportunity to present my views on the VA health care delivery system in Puerto Rico.

I commend the Subcommittee for its efforts to keep abreast of and address each of the wide array of complex and particular problems confronted by veterans all across the Nation including those of our veterans on the Island.

Mr. Chairman, there is a compelling need to review the VA health care delivery system in Puerto Rico. The lack of VA medical facilities in Puerto Rico forced the VA to contract out services during the Roosevelt Administration and 40 years later the VA still depends significantly on the private sector to provide medical attention to the thousands of eligible veterans in Puerto Rico. Although since 1969 we have had a VA Medical Center in Puerto Rico, its facilities are insufficient. The VA has needed in the past and will continue to need in the future, until additional facilities are provided, special authority from Congress to contract out health care services with private suppliers in Puerto Rico. The arrangement prima facie seemed

appropriate and conforming to need. Unfortunately, an in depth look by GAO in 1978 which was subsequently ratified by the VA in two separate reports to Congress on health care of veterans in Puerto Rico presented in April 1981 and January 1983, proved otherwise. Even though the overall medical care provided by General Medicine and Surgery contract hospitals is satisfactory, the quality of psychiatric care in contract hospitals including sanitation, safety and physical facilities were found to be below the standards of the VA in some instances and totally inadequate in others.

The present VA facilities on the Island are good but inadequate and to this date and age are unable to absorb the additional work load. Currently, the VA contracts over 500 beds with the private sector to supplement its inpatient care. The VA's only inpatient facility on the Island is a 692 bed medical center which operates with an occupancy rate of over 90 percent. The VA's Medical District Initiated Program Planning (MEDIPP) guidelines state that the average annual occupancy rate should be approximately 85 percent to allow for the optimum management of patient flow. Usually, the only beds available in the VA Center in San Juan are those reserved for acute emergencies or specialized procedures such as Intensive Care, Dialysis, Coronary Care, etc. The Center has consistently received the largest number of applications for hospitalization in the entire VA system. In addition, during FY 82 it treated 17,378 patients which would rank the VAH in San Juan ninth among the 172 VAH

Nation-wide. The VA personnel are doing the utmost to provide high quality of inpatient health care to every needy eligible veteran in Puerto Rico but if more resources are not put at their disposal, many ill veterans on the Island will continue to suffer inadequate medical attention.

The VA Medical Center in San Juan operates one of the largest outpatient programs in the VA system, from the standpoint of both staff and fee basis programs. The FY 82 work load for these programs of over 237,000 staff visits and 88,791 fee visits ranked us eight and second respectively system-wide. There is an unusually high number of walk-in applicants in our VA Medical Center and the Mayaguez Satellite Clinic averaging over 300 veterans daily. The current outpatient space is extremely limited in relation to need. This precludes the proper management of patients access to treatment in the fee program and hinders the VA's efforts to ensure that quality care is provided in the program.

The well being of our senior veterans in Puerto Rico is also an area of great concern to me. Presently, there are no VA nursing homes in Puerto Rico and the VA contracts 50 beds for the aged veterans. There are 13 non-VA nursing homes on the Island with a bed capacity of 987 of which all but few are below VA standards. This means that there are 5.9 beds per 1,000 inhabitants over 65 years of age in Puerto Rico as compared to 65.6 beds per 1,000 persons over 65 years of age in the U.S. mainland. By 1990 is estimated that over 33,000 veterans will be

over the age of 65 in Puerto Rico. Time is long overdue for us to address this issue so that our senior veterans can live in peace and minimum comfort during their advance age.

Mr. Chairman, it is a known fact that most veterans in Puerto Rico rely on the VA system for medical assistance and that their demand for care is higher than in any other place in the VA system. In the VA's Report to Congress on Health Care for Veterans in Puerto Rico and the Virgin Islands, presented on April 9, 1981, four valid reasons are provided to explain this situation: (1) the rate at which acute conditions occur is higher in Puerto Rico than in the U.S. mainland, indicating a somewhat poorer health status than for U.S. veterans in general; (2) mental health problems occur at higher rate in the case of veterans in Puerto Rico than in the VA system as a whole; (3) the average Puerto Rican veteran cannot afford fee for service care; (4) the quantity of public health services provided by the Puerto Rican government are inadequate in relation to need. I may add that a major factor contributing to the last of these causes is that Medicaid applies in Puerto Rico on a very limited basis with the federal government providing only $45 million while the Puerto Rican government provides over $170 million. Currently, in the non-VA sector of health care, there are one half the number of beds per 1,000 inhabitants in Puerto Rico than in the U.S. mainland. In addition, 26 percent of the service-connected veterans in Puerto Rico are severely disabled as opposed to 7 percent VA system wide. Five percent of veterans on the Island

are service-connected for psychiatric problems as compared to two percent system wide.

In 1979 when the unemployment rate in Puerto Rico was 17 percent, thirty-four percent of the veterans came from families with an income below $7,000; 42 percent from families with an income between $7,000 to $14,000 and only 24 percent from families with incomes over $15,000. In 1983 when the official unemployment rate is over 25 percent these figures are even more dramatic.

As you know, the House and Senate Committees on Veterans Affairs, moved by the unfair and unwarranted situation being confronted by many needy veterans on the Island, responded in a sensible and responsible fashion and in August 18, 1982 requested from the VA a comprehensive plan to remedy the deficiencies of the VA health care system on the Island. On January 20, 1983 the VA's report "A Plan for the Delivery of Health Care to Veterans in Puerto Rico and the Virgin Islands" was presented to Congress. The Report ratifies previous findings by GAO and the VA that additional facilities have to be placed at the disposal of the VA in Puerto Rico to enable it to carry out its responsibilities on the Island. Unfortunately, the letter of transmital of the Report and its executive summary contained a disclaimer of responsibility by the VA and the Administration. This unexpected situation raised the concern of many of our colleagues in the House as well as mine. Finally, the issue has been somewhat cleared up by the VA authorities by explaining that the scope of

this language is circumscribed to FY 84 and not to the issue as a whole. Mr. Chairman, a great deal of uncertainty still prevails regarding any possible changes in the VA health care system on the Island. I believe Congress should continue to closely monitor any progress made to resolve the unwarranted situation faced by our veterans on the Island. Therefore, I support the extension of the contract authority to the VA only for one additional year. This would allow sufficient time for the VA to assume a definite stance on a remedial course of action. Congress, on the other hand, will be in a better position to assess the time the VA's reparatory plans require to be carried out and grant a final extension to the contract authority next year. This, of course, provided the health care needs of the veterans on the Island have been properly addressed by the VA.

Mr. Chairman, I have not come before this Committee to request a preferential treatment but only equal treatment. It is only fair play that the veterans in Puerto Rico should receive the same quality of medical attention accorded to veterans in the U.S. mainland. Their efforts and sacrifices on behalf of our democracy and freedom were no different. More than 270,000 Puerto Ricans have served in the Armed Forces since 1917. Thousands of Puerto Ricans have died or have been wounded in U.S. wars. Their deeds were highlighted during the Korean War where the death and casualty rates among Puerto Ricans would rank us third among all states and territories, in proportion to our population. Their human contribution surpass any possible

retribution and we Puerto Ricans, as American citizens, are always willing to serve gallantly and to prove our loyalty to the United States. Our Nation has endured thanks to men like these and proper medical attention is the least a good soldier deserves.

Given the undisputed reality portrayed by numerous studies that additional VA facilities are sorely needed on the Island, we must focus on construction alternatives early on in this Congress if quality health care is to be available for every ill veteran in Puerto Rico by the end of the decade. I particularly support the construction of a 480 bed psychiatric wing in the VAH in San Juan; the construction of a 120 bed nursing home in San Juan; the establishment of an outpatient clinic in Ponce and the expansion of the existing outpatient clinic in the VAH in San Juan.

The offering of complete medical attention to our veterans in Puerto Rico is long overdue and these additional facilities would allow it. I urge this Committee to use its wisdom in securing proper medical attention to our veterans on the Island not only for humanitarian reasons but also because these brave and loyal servants have rightfully earned it.

STATEMENT
SUBMITTED FOR THE RECORD
TO
HOUSE VETERANS AFFAIRS COMMITTEE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
ON THE
VETERANS ADMINISTRATION MEDICAL
CONSTRUCTION PROGRAM

March 16, 1983

The National Council of Health Centers would like to take this opportunity to comment on the Veterans Administration (VA) medical construction program, particularly the construction of nursing home facilities.

Members of the National Council are investor owned multifacility nursing home corporations which own or manage approximately 200,000 beds in nursing facilities in 48 states and the District of Columbia. Our member firms also provide many other health related services such as home health, alcohol and drug rehabilitation programs, retirement centers and hospice services. In addition, many of our members supply care to aging veterans through contractual arrangements with the VA.

Because we are actually involved in providing professional care services to many elderly and disabled veterans, we are concerned that the VA's nursing home care program and the process it uses to plan for meeting further nursing home care needs are inadequate.

The need for new VA nursing home beds is critical. To substantiate this, one need only look at the VA's own projections. By the year 2010, there will be more than a million veterans over age 85, compared with 130,000 in 1977. According to the VA publication, The Aging Veteran Present and Future Medical Needs, (1977) "should current rates prevail, they alone might require 250,000

nursing home beds." We cannot ignore the fact that this group is one of the most rapidly growing segments of our population. As more veterans live longer, their health needs inevitably increase.

In that context, the important issues relating to new construction raised by the General Accounting Office (GAO) ("VA Should Consider Less Costly Alternatives Before Constructing New Nursing Homes," GAO/HRD-82-114, Sept. 20, 1982) are of concern to us in assuring that our rapidly aging veteran population has access to the quality of health care they richly deserve.

To help meet future needs for direct provision of nursing home care in its own facilities, the VA has requested funding for several new units in fiscal year 1983. The GAO's statement that "the cost of new VA nursing home construction is much higher than that in the private sector . . ." is not surprising; the difference in the costs, however, are striking. Construction of two VA facilities are as follows:

Location	Number of Beds	Total Estimated Costs
Hines, IL *	120	$10.905 million
San Antonio, TX	120	10.1 million

* To be added through vertical expansion of a 120-bed unit presently under construction.

A total of 240 net beds would be added to the VA's nursing home capacity at a projected cost of $21.05 million or about $87,~~700~~ 520 per bed. Comparable bed size facilities recently constructed by National Council member organizations are as follows:

Location	Number of Beds	Total Costs
Dunedin, FL (opening April 1983)	120	$3.0 million
Albuquerque, NM (opening April 1983)	120	$3.23 million
Charleston, SC (1982)	132	$3.20 million

The cost for the construction of these 372 beds in the private sector was $9.43 million, or about $25,350 per bed.

The lower costs incurred by our member organizations are attributable in part to their expertise in the economics of health facility construction management, as well as their being able to benefit from the efficiencies and economies of scale. We are very hard pressed to account for the VA's cost estimates. While geographic location, total square footage and other factors could justify some of the higher costs associated with VA construction, we are at a loss to explain an amount three times the cost of private sector construction of similar 120-bed facilities.

Indeed, we believe that the VA also has the resources and financial ability to construct nursing homes in an efficient and economic manner. The Reagan administration has proposed a record high budget of $868 million for the construction of health facilities with $67.3 million earmarked for the design and construction of seven nursing homes in various locations. We believe that congressional scrutiny of the VA's planning, designing and construction of nursing home care units is necessary. Specifically, we believe the following areas should be reviewed:

- Federal Procurement Procedures - The burdensome procedures associated with federal procurement are not conducive to cost savings. Although

the federal government accepts low bids, allowing negotiations with the successful bidder would be more cost efficient. In addition, once a contractor has won a contract, any construction or design changes are potentially expensive.

- Labor Construction Costs - Provisions of the Davis-Bacon Act requiring contractors performing construction work for the federal government to pay its employees no less than wages prevailing in the area where the work in being performed can add as much as 20 percent to costs.

- Design Techniques - Critics of the VA nursing home construction program have pointed to several costly design techniques: constructing facilities with hospital rather than nursing home standards, in effect, placing a long term care patient in a hospital setting; providing facilities with unnecessary hospital related equipment; and tying new construction to existing facilities, an expensive job due to the necessity of matching the new and old facilities.

- Safety Features - Have VA facilities gone beyond safety measures incorporated by the Life Safety Code, the Department of Housing and Urban Development, or state or local jurisdictions? Any additions of unnecessary and costly safety equipment and material should be questioned.

- Increase the contracting for community based nursing home beds in private facilities as noted by the GAO in its report.

- Consideration of establishing master contracts with providers of nursing home services to construct and manage facilities for the principal or exclusive use of VA patients.

We believe that these factors and others must be closely reviewed by the GAO and appropriate congressional committees to assure that the expenses and projected costs of VA nursing home construction programs are economical and efficient, while assuring that each veteran has access to quality health care.

The National Council is prepared to assist the VA in providing nursing home services to its health program beneficiaries.

In summary, we are concerned that the VA's nursing home care program and the process it uses to plan for meeting future nursing home care needs is not economical or efficient. Procedures relating to federal procurement, labor, design techniques and safety features should be examined with careful consideration given to less costly alternative construction methods.

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
MARCH 16, 1983

Mr. Chairman and Members of the Subcommittee:

The American Legion is appreciative of this opportunity to present its views on the Veterans Administration medical construction program for Fiscal Year 1984, and related matters.

It must be said that The American Legion is gratified for the manner in which the Administration has responded to the ongoing need for renovation and replacement of facilities within the VA medical care system in its FY 1984 Budget proposal, by recommending an increase of $319 million in the construction programs for a total of $868 million. Most of this is allocated to the medical care program.

Mr. Chairman, we are extremely pleased to see that $254 million of the budgeted construction funds are earmarked for the Minneapolis replacement hospital, as originally proposed, with 725 acute care and 120 nursing home care beds. The American Legion has continually espoused the urgency of this badly needed and long overdue project, and we look forward to its progression.

The Veterans Administration Facility Planning and Construction Committee has completed its study and revalidation process of the major construction projects for FY 1984, and for the most part, as we expected, it was determined that there is ample justification for the projects, although further development was required in

some cases.

As you are aware Mr. Chairman, in response to the revalidation initiative, The American Legion provided VA with information relating to construction needs at the identified projects that was extracted from the site visit reports of our Field Representatives, updated where necessary, and developed into exhibits for each of the projects. This Subcommittee was provided copies of the reports. The information indicated that in nearly every single instance, the projects were reflective of the actual needs within the VA medical care system.

An area of the VA medical construction program that concerns The American Legion is the amount of time between the conception of a project, once the need has been determined, and the completion of construction. It is apparent to us that there is a definite need for steps to be taken to abbreviate the construction planning timetable.

In reviewing the FY 1984 Budget proposal, it was noted that for the first time, authorization was requested to expend appropriated funds to accomplish working drawing designs on five projects which are to be given high priority consideration for the Administration's FY 1985 Budget proposal. By preparing the working drawings during FY 1984, it is acknowledged that construction on the five projects can begin early in 1985, provided they are approved and funds are appropriated. To The American Legion this is a sensible approach to shortening the time span.

In addition, the General Accounting Office report entitled

"Opportunity to Reduce the Cost of Building VA Medical Facilities", that was prepared at the request of this Subcommittee, pointed out that an extension of the Advanced Planning Fund to allow VA to contract for final designs while Congress reviews the projects could reduce overall costs. GAO stated that the time it takes to complete medical facility construction projects could be reduced by up to 15 months by extending the fund, which would necessitate Congressional action to amend VA's construction authority under 38 USC 5001.

The ability to expedite the development and completion of VA construction projects by 15 months, in the Legion's thinking, would result in substantial cost savings when compared to the lengthy course of proceedings that the projects currently undergo, and we feel that such a concept is worthy of consideration, provided VA controls the number of change orders to the construction contracts. Modifications to contracts lead to slippage on completion time and result in increased construction costs.

The VA medical care system consisting of 172 hospitals and 225 outpatient clinics represents a multi-billion dollar capital investment of the Federal Government in the most comprehensive health care delivery program in existence in this country, and probably in the world. It is an aging and deteriorating system that includes hospitals built before World War II, and uses some buildings much older than that. These aging structures were not configured to adapt to the practice of modern medicine. Therefore there is an immediate and ongoing need for renovation and replacement

of facilities within the VA system.

The Medical District Initiated Program Planning Project implemented by the Department of Medicine and Surgery has produced some initial findings as a result of each Medical District's reassessment of its current and future needs. More likely than not, judging from our review of available MEDIPP data, mission changes at some VA medical centers will lead to some changes in future facility construction plans. And The American Legion will be watching this situation closely, as a consumer advocate for the nation's veterans.

Mr. Chairman, as was stated at the outset, The American Legion is pleased with the much needed increase in the Medical Construction Program proposed in the Administration's FY 1984 VA Budget request. We have been extremely concerned in past years when proposed construction funding has been reduced during budget negotiations in Congress.

The justification for each of the construction plans contained in the budget proposal has been substantially documented, and The American Legion urges full funding for each of these projects.

We again thank the Subcommittee for the opportunity to present our views on these important matters.

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